

**MEDICAL RELEASE FORM**

Woodmont Baptist Church Children’s Events

Dates: January 1, 2022 to December 31,2022

Name: \_\_\_\_\_ Age: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

In Case of Emergency Notify: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Heath Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policyholder’s Name \_\_\_\_\_ Policyholder’s SS# \_\_\_\_\_

Immunizations (mark all that apply): \_\_\_ Tetanus \_\_\_ Polio Booster \_\_\_ Measles \_\_\_ Mumps

\*\*\* I authorize that my child is permitted to have a non-drowsy Dramamine \_\_\_ yes \_\_\_ no

\*\*\*\*\*

**\*\*\*Please write none where applicable on this section\*\*\***

ALLERGIES: \_\_\_\_\_

Previous operations or serious illnesses: \_\_\_\_\_

Current medications being taken: \_\_\_\_\_

Special Diet: \_\_\_\_\_

\*\*\*\*\*

Being the parent or legal guardian of \_\_\_\_\_, I \_\_\_\_\_

Do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child. Further, I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the Children’s Minister, or Chaperone, to make decisions necessary for treatment. Should there be no Children’s Minister, or Chaperone, available, I give permission to the attending physician to treat my minor child. I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care.

I, the undersigned, do hereby verify that the above information is correct and I do hereby release and forever discharge all sponsors and Woodmont Baptist Church from any and all claims, demands, actions or cause of action, past, present, or future arising out of any damage or injury while participating in any 2022 event.

Dated this \_\_\_ day of \_\_\_\_\_, 20\_\_\_

Parent/Guardian Signature \_\_\_\_\_

State of \_\_\_\_\_ County of \_\_\_\_\_

I, the undersigned authority, a notary public in and for said county in said state, hereby certify that \_\_\_\_\_, whose name as parent or legal guardian of \_\_\_\_\_ is signed to the foregoing medical release form, and who is known to me, acknowledged before me on this day that, being informed of the contents of said instrument, he/she as such parent or legal guardian and with full authority, executed the same voluntarily.

GIVEN under my hand and official seal this is \_\_\_ day of \_\_\_\_\_, 20\_\_\_.

\_\_\_\_\_ My commission expires \_\_\_\_\_

Notary Public

**MUST BE 19 YEARS OLD OR OLDER IN ORDER TO SIGN FOR YOURSELF**