MEDICAL RELEASE FORM 2024
FIRST BAPTIST CHURCH, RICHMOND, KY

(PLEASE PRINT)

Name of Student_____ Date of Birth_____
Address _____ Age_____
City_____ State_____ Zip_____
Phone Number (___)_____ Sex____ Height_____ Weight_____

Emergency Contact Person:

Parent/Guardian Name_____
Address (if different from student)_____
City_____ State_____ Zip_____
Phone Numbers: (H) (___)_____ (W) (___)_____ (C) (___) _____

Alternate Contact Person: (Use someone other than Parent/Guardian):

Name_____
Address (if different from student)_____
City_____ State_____ Zip_____
Phone Numbers: (H) (___)_____ (W) (___)_____ (C) (___)_____

If you have medical insurance, you or your carrier will be billed for medical charges in the case of illness or injury while your child is at the activity. **If you do not have insurance you will be billed.**

Do you have health insurance? _____ Yes____ No____
Name of Insurance Co. _____Phone Number (___)_____
Policy Number_____ Group Number _____
In whose name is the insurance? _____
Family Physician _____ City _____
Physician Phone Number (___)_____

(Please turn over and complete the Health History)

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If your child should require medical attention for injuries received or illnesses contracted prior to activity, please send us the necessary information to give him/her proper medical care during his/her time with the youth ministry activity. If they are currently on medication we ask that they NOT stop taking that medication while on a youth ministry activity.

Health History:

Pre-existing or present medical conditions _____

_____

Name and dosage of any medications that must be taken _____

_____

Any allergies? _____ To medications? _____

____ Hay Fever ____ Heart Condition ____ Diabetes ____ Insect Stings

____ Epilepsy/Nervous Disorders ____ Asthma ____ Frequent Stomach Upsets

____ Physical Handicap ____ Other _____

____ Any major illnesses during the past year?

If any of the above are checked, please give details (i.e., include normal treatment of allergic reactions)

_____

_____

Date of Last Tetanus Shot _____ Contact Lenses? _____

Any activity restrictions? _____ Yes _____ No

What? _____

Please use the remaining page to give any other pertinent information to us.