MEDICAL AUTHORIZATION & RELEASE FORM

First Baptist Church - Panama City, Florida

Last Name: _____ First Name: _____
Address: _____
City: _____ State: _____ Zip:_____
Date of Birth: _____/_____/_____ (MM/DD/YYYY)
Home Phone: _____ / Cell Phone: _____
Father's Name: _____
Employer: _____
Work Phone: _____ Cell Phone: _____
Mother's Name: _____
Employer: _____
Work Phone: _____ Cell Phone: _____

I give First Baptist Church and its representative's permission to email my child at:
Email address: _____

1. Emergency Contacts (In the event that a parent cannot be contacted.)
_____ Phone: (____) _____Relationship:_____
_____ Phone: (____) _____Relationship:_____
_____ Phone: (____) _____Relationship:_____
2. Family Physician: _____ Phone: (____) _____
3. Hospitalization & Major Medical Insurance Company: _____
Policy Number: _____ Group Name and/or Number: _____
Type of Coverage: _____Major Medical ____Hospitalization ____Dental
____Other: _____
4. Family Dentist: _____ Phone: (____) _____
5. Known Allergies: _____
_____
6. Medications:
A. Prescriptions (List medicine & dosage) _____
_____
B. Non-Prescriptions (List medicine & dosage) _____
_____

I give First Baptist Church permission and its representative's to take pictures of my child and to use those pictures for publicity purposes.

I UNDERSTAND THAT THERE IS NO WORKER'S COMPENSATION OR ACCIDENT INSURANCE PROVIDED BY THE FIRST BAPTIST CHURCH OF PANAMA CITY OR ANY MINISTRY OF THE CHURCH.

Please fill out SECOND page!

RELEASE FROM LIABILITY AND AUTHORIZATION FOR MEDICAL TREATMENT

In the event that (your child's name)_____becomes ill and/or sustains and injury while attending any function or trip sponsored by FIRST BAPTIST CHURCH OF PANAMA CITY, FLORIDA, I, the undersigned parent/guardian, give my permission to those in charge to take whatever steps deemed necessary to stop any bleeding, to administer first aid and to secure any medical/emergency treatment.

I also give my consent to any x-rays, examination, anesthetic, medical, dental or surgical diagnosis and treatment, hospital care and the administration of medications to be rendered in an emergency situation, under the general and/or specialized supervision of a duly licensed physician and/or surgeon.

I furthermore understand and agree that a copy of this form will be as valid as an original. I understand and agree that this signed copy releases the sponsors, chaperones, the First Baptist Church of Panama City, its ministers, staff and employees of any and all liability (including acts of negligence) in the event that the above named person should be injured. I give my permission to the above mentioned chaperones and/or sponsors to secure first aid and/or medical treatment and I, furthermore, authorize the physician to proceed with any emergency medical treatments as deemed necessary.

I furthermore agree to be personally responsible for any financial obligations incurred by the above mentioned treatments not covered by my major medical insurance.

STOP: **This form <u>MUST</u> be signed by a parent or legal guardian <u>IN THE PRESENCE OF A NOTARY</u>.**

SIGNATURE OF CONSENT: _____
PRINTED NAME: _____
DATE: _____/_____/_____
(MM / DD / YYYY)

(To be completed by Notary)

STATE OF FLORIDA
BAY COUNTY

The foregoing instrument was acknowledged before me this _____ day of _____, 20____, by _____, who

_____is personally known to me, or
_____produced _____as identification and did take an oath.

(Affix seal below)

_____
Notary Public