

MEDICAL RELEASE FORM 2011

Name: _____ Age: _____
(Last) (First) (Middle)

Home Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ DOB: ____ / ____ / ____ Place of Birth: _____
(City) (State)

Home Phone Number: (____) _____ Parent's Office Phone: (Dad) _____

Parent or Guardian: _____ (Mom) _____

Insurance (be specific, ex: Blue Cross Blue Shield of Texas): _____ Phone: _____

Primary Insured Name: _____ Policy Number: _____

Primary insured Drivers License: _____ Group Number: _____

Primary Insured Company: _____

In the event of an emergency, give the name and phone number of friends or relatives we can contact who will know how to reach parents or guardians:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

List known food/drug or other allergies: _____

List medications taken regularly: _____

Swimming: My youth is a: Non-Swimmer _____ Fair Swimmer _____ Good Swimmer _____

PARENT / GUARDIAN PERMISSION:

I hereby give my permission for _____ to take part in all Mid-Cities activities. I hereby give my permission for the designated / approved church representative, alto frio encampment, or sponsor to secure any needed medical treatment for the above name son / daughter. I release Every Nation Ministries, Alto Frio Baptist Encampment & Mid-Cities Community Church from liability for accident or injuries on these trips or activities.

I further understand and agree that, in the event that the above named son / daughter be involved in any non-Christian or dangerous activities, I will pay his or her expenses to be sent home immediately at the discretion of the approved sponsors and / or church representatives.

I have supplied, understood and agree to all the information contained on this Medical Release Form.

(Date)

(Parent/Guardian Signature)

Has camper had:

Appendix removed? _____

Chickenpox? _____

Fainting spells? _____

Asthma? _____

Heart trouble? _____

Convulsions? _____

Diabetes? _____

Allergies to food or medicine? _____

Specify _____

Allergies to bites or stings? _____

Specify _____

Any other allergies? _____

Specify _____

Medication Authorization:

Is student taking any medication that must be given at camp/event? _____

If yes, please complete the following:

Please administer to _____

The following medication(s): _____

Dosage: _____

Time: _____

Alto Frio Camp Date: July 18th thru 22nd

Or Church Event

Signature: _____

THIS MEDICAL RELEASE FORM VALID FOR ONE CALENDAR YEAR FROM DATE SIGNED.

**For Office Use Only:
Medical Release Form**

Received by: _____

Date Received: _____