

Second Baptist Church

2504 MOODY ROAD ♦ WARNER ROBINS, GEORGIA 31088
(478) 923-7101 ♦ FAX (478) 923-7475 ♦ WWW.SBCWR.ORG

MEDICAL INFORMATION AND LIABILITY RELEASE FORM Valid January 1, 2011– June 30, 2011

To insure the safety of the student, this form must be completed in its entirety for each student. All information will be treated with utmost confidentiality.

FULL NAME OF STUDENT _____	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
ADDRESS _____		
CITY _____	STATE _____	ZIP _____
SOCIAL SECURITY NUMBER _____ - _____ - _____	BIRTHDAY (mm/dd/yyyy) ____/____/____	
HEIGHT _____	WEIGHT _____	HOME PHONE (____) _____ - _____

FULL NAME OF PARENT OR GUARDIAN _____		
ADDRESS (if different from student) _____		
CITY _____	STATE _____	ZIP _____
HOME PHONE (____) _____ - _____	CELL PHONE (____) _____ - _____	
WORK PHONE (____) _____ - _____		

ALTERNATE CONTACT PERSON (**someone with a different address and phone number**)		
FULL NAME OF ALTERNATE CONTACT _____		
ADDRESS _____		
CITY _____	STATE _____	ZIP _____
HOME PHONE (____) _____ - _____	WORK PHONE (____) _____ - _____	

NOTE: If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while your child is at a church-sponsored activity.		
HEALTH INSURANCE PROVIDER _____		
POLICY NUMBER AND GROUP NUMBER _____		
IN WHOSE NAME IS THE INSURANCE? _____		
SOCIAL SECURITY NUMBER OF INSURED INDIVIDUAL _____ - _____ - _____		

(OVER)

STUDENT'S PHYSICIAN _____ PHONE (_____) _____ - _____

CITY _____ STATE _____ ZIP _____

PRE-EXISTING OR PRESENT MEDICAL CONDITIONS (please detail):

NAME AND DOSAGE of medications that are presently prescribed or taken regularly by the student: _____

ALLERGIES (*insect bites/stings, drugs, etc.*) Please detail the allergic reaction and include normal treatment for the reaction:

OTHER: (please check all that apply)

<input type="checkbox"/> Heart	<input type="checkbox"/> Frequent Stomach Upsets	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Asthma
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Contact Lenses
<input type="checkbox"/> Chronic Condition	<input type="checkbox"/> Physical Handicap	<input type="checkbox"/> Other	

If any of the above are checked, please give details:

Date of LAST Tetanus Shot: _____ Swimming Restrictions: _____

Any Activity Restrictions: _____

MEDICAL AND LIABILITY RELEASE STATEMENT

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I cannot be reached in an emergency, I hereby give my permission to the physician or dentist selected by the activity leader to hospitalize, to secure medical treatment and/or to order an injection, anesthesia, or surgery for my child as deemed necessary.

I understand that my insurance coverage for my child will be used as primary coverage in the event medical intervention is needed. Coverage by Second Baptist Church through its accident policy will be used as a back-up for what my family's insurance does not cover.

I understand all reasonable safety precautions will be taken at all times by Second Baptist Church and its agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold Second Baptist Church, its leaders, employees, and volunteer staff liable for damages, loses, diseases, or injuries incurred by the subject of this form.

Signature Of Parent or Guardian

_____/_____/2011
Date