Form Must Be Notarized

Medical Release Form
Byne Memorial Baptist Church
January 1- December 31, 2020

2020

Participant Name _____ Date of Birth _____

Address _____
(Street) (City) (State) (Zip)

HEALTH INFORMATION (Provide all known information.)

BLOOD TYPE _____ Date of Last Tetanus Shot: _____

Is participant subject to:

ALLERGIES (Food /Medications/Latex/Tape/Insect bites/Seasonal/Other?) Please list below:

_____

If yes (☑) to any of the following, please describe on reverse in comments area:

☐ Asthma ☐ Blood Pressure ☐ Diabetes / Hypoglycemia ☐ Epilepsy ☐ Fainting ☐ Heart Trouble

☐ Orthopedic Problems ☐ Other _____

List any special dietary needs? _____

CURRENT MEDICATION (Prescription/over counter/contact lens/etc.) _____

Permission granted to give participant the following over the counter meds: ☐ Yes ☐ No

☐ Antihistamine/Decongestants ☐ Artificial tears ☐ Diarrhea/Nausea Medication ☐ First Aid Cream

☐ Motion Sickness Medication ☐ OTC Pain med (Advil, Tylenol, etc.)

I hereby give permission for my son/daughter/self (if over 18 years of age) in the event of illness or injury to receive emergency medical care including x-ray examinations, laboratory procedures, anesthesia, medical or surgical treatment or other hospital services ordered by the attending physician or dentist. I also authorize the release of all information necessary to settle any insurance claims. I understand I am responsible for all charges not covered by insurance. I understand that in the event of medical intervention is needed; every attempt will be made to contact the person(s) on back immediately. _____ (Initial here)

In consideration of the right to participate in the activities and service arranged for my son/daughter/self (if over 18) by Byne Memorial Baptist Church, I have and hereby assume for my son/daughter/self all risk and hold Byne Memorial Baptist Church and all persons associated with it in any way harmless from any and all liability, action, cause of action, debts, claims, demands of every kind and nature whatsoever which may arise from or in connection with his/her/my participation in its programs, events, activities. The terms shall serve as a release and assumption from all risk and liability for my son/daughter/self. _____ (Initial here)

If my son/daughter/self (if over 18) presents a behavior problem, as deemed so by an employee or volunteer of Byne Memorial Baptist Church, I give the employee and/or volunteer of Byne Memorial Baptist Church and/or the employees of the establishment/facilities being used, to exercise any reasonable discipline as the occasion permits. I understand that this may include the returning home the participant, with any expense incurred my responsibility. _____ (Initial here)

Signature_____
Parent or Legal Guardian or Applicant if over 18

Date _____

INSURANCE AND EMERGENCY CONTACT INFORMATION (On Reverse Side)

State of Georgia, County of _____
Sworn to and subscribed before me

This _____ day of _____, 2020

SEAL REQUIRED

_____
Notary Public for Georgia

My commission expires _____

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INSURANCE INFORMATION – *Please attach copy of medical insurance card*.

Is participant covered under a medical insurance plan? ☐ Yes ☐ N**o**

If YES, please provide following information -

NAME OF INSURANCE COMPANY_____

POLICY # _____

GROUP # _____

POLICYHOLDER_____

RELATIONSHIP TO PARTICIPANT_____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

If NO, please initial below:

"I understand that I am responsible for any/all medical expenses that could result from an illness or injury to participant while on said event." _____ (Initial here).

EMERGENCY CONTACT INFORMATION:

Primary Contact _____

Relationship to Participant _____

Address _____ Phone _____

Cell Phone _____ Alternate Cell Phone _____

Secondary Contact _____

Relationship to Participant _____

Address _____ Phone _____

Cell Phone _____ Alternate Cell Phone _____

COMMENTS OR ADDITIONAL INFORMATION –

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