CHILDREN'S MEDICAL RELEASE FORM

Student's Name: _____ Parent's Name: _____ _

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

Phone: _____ Other Phone: _____

PARENT: I, _____, the undersigned parent or person having legal custody or the legal guardian of above named minor give permission for the above named minor to participate in Oak Grove Baptist Church's activities for the 2012 and 2013 year and do hereby authorize H. Andrew Rist, Josh Brown, Patrick Wood or appointed representative or any sponsor by the above mentioned to consent to any x-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment and hospital care to be rendered to the above named minor under general or special supervision and upon the advice of a physician, surgeon, or dentist licensed under the laws of the state they practice in. In giving this consent I recognize and understand that in situations where the named minor requires immediate medical or hospital care it may not be possible to contact me, in such situation I will not be able to knowledgeably evaluate and chose among the available alternative treatments or procedures, if any, or to evaluate the risk attenuate upon each, and the risk attenuate to forgoing all treatment in such situations, I authorize a physician, surgeon, or dentist to exercise his professional judgment and assess the risk incident to and chose the necessary treatment from any available alternatives and to render such care and perform such treatment as he in his professional judgment determines to be necessary for the health or safety of the above named minor. I also agree to reimburse any expenses not covered by the Church's insurance. I will not hold the church or any of the workers responsible for any illness or injury to my child.

* Remember that appropriate Christian behavior is expected by all children. I agree to provide transportation back home for my child due to any and all misconduct.

_____

(Signature of parent or legal guardian) (date)

MEDICAL INFORMATION

Name of Medical Insurance Company _____ Policy Number

_____

Date of last tetanus shot

_____

Any health problems, physical limitations, etc:

_____

Any allergies, or medicines, drugs, or shots person is allergic to:

_____

_____

If the child is on prescription medicine, give name of medication(s) and directions for administering:

_____

Person(s) to notify in the event of serious illness or injury:

Name: _____

Address:_____

City: _____ State_____ Phone _____

Other Phone_____