FIRST BAPTIST CHURCH OF ASHLAND ~ 2004 SISKIYOU BLVD ~ ASHLAND, OR 97520

MEDICAL & LIABILITY RELEASE FORM

STUDENT INFORMATION

NAME: ______________________________ BIRTHDAY: ____________ GRADE: _____

PHONE: _____________ CELL PHONE: _____________ EMAIL: _____________________

ADDRESS: ________________________ CITY: __________ STATE: ____ ZIP:__________

EMERGENCY INFORMATION

PARENT/GUARDIAN: ____________________________ HOME PHONE: _____________

EMAIL: ____________________________________ WORK PHONE: _____________

CELL PHONE: ______________

IN THE EVENT THAT THE ABOVE PERSON CANNOT BE REACHED, PLEASE CALL:

NAME: ____________________________________ HOME PHONE: _____________

WORK PHONE: _____________

CELL PHONE: ______________

DOCTOR: ________________________________ TELEPHONE: ___________________

DO YOU HAVE HEALTH INSURANCE? YES ☐ NO ☐

NAME OF MEDICAL INSURANCE CARRIER: _____________________ POLICY #: _____________

CARRIER'S ADDRESS: ____

HEALTH HISTORY

ALLERGIES:

DRUG ALLERGIES ☐
ASTHMA ☐
HAY FEVER ☐
INSECT STINGS ☐
FREQUENT STOMACH UPSET ☐
OTHER ☐ _______________

MAJOR PROBLEMS:

DIABETES ☐
CARDIAC ☐
NERVOUS DISORDER ☐
EPILEPSY ☐
FREQUENT COLDS ☐
OTHER ☐ _______________

HIGH BLOOD PRESSURE ☐
CHRONIC ASTHMA ☐
PHYSICAL HANDICAP ☐
EMOTIONAL HANDICAP ☐
MENTAL HANDICAP ☐
SEIZURE DISORDER ☐

FBC MEDICAL AND LIABILITY RELEASE (PAGE 2)

IF YOU CHECKED ANY OF THE ALLERGIES OR MAJOR PROBLEM AREAS ON THE PREVIOUS PAGE, PLEASE GIVE DETAILS (INCLUDE NORMAL TREATMENT OF ALLERGIC REACTIONS):

DATE OF LAST TETANUS SHOT: ___________________________

NAME AND DOSAGE OF ANY MEDICATIONS THAT MUST BE TAKEN:

ACTIVITY RESTRICTIONS? YES ☐ NO ☐ IF YES, WHAT ACTIVITY? _________________________

SWIMMING RESTRICTIONS? YES ☐ NO ☐

DIET RESTRICTIONS? YES ☐ NO ☐ IF YES, WHAT RESTRICTIONS? _____________________

PERMISSION TO DISPENSE ANY OF THE FOLLOWING MEDICATIONS, IF NECESSARY.

TYLENOL ☐	IBUPROFEN ☐	ACETAMINOPHEN ☐	SUDAFED ☐
DECONGESTANT ☐	DIARRHEA MEDICINE ☐	TUMS ☐	ANTIHISTAMINE ☐
COUGH SUPPRESSANT ☐	DRAMAMINE ☐	THROAT SPRAY ☐	THROAT LOZENGES ☐

PLEASE CHECK THE BOXES OF THE MEDICATIONS YOU APPROVE OF USING. BOXES LEFT BLANK WILL NOT BE ADMINISTERED TO YOUR CHILD WITHOUT PERMISSION.

EVERY ACTIVITY SPONSORED BY FIRST BAPTIST CHURCH OF ASHLAND IS CAREFULLY PLANNED AND ADEQUATELY STAFFED BY MATURE ADULTS. HOWEVER, EVEN WITH THE BEST OF PLANNING AND PRECAUTIONS, UNFORESEEN EVENTS CAN OCCUR. BY SIGNING THIS FORM, THE PARENT/GUARDIAN AGREES TO ASSUME AND ACCEPT ALL RISKS AND HAZARDS INHERENT IN CHURCH-RELATED SOCIAL ACTIVITIES. THEY ALSO AGREE NOT TO HOLD THIS CHURCH OR ITS EMPLOYEES OR VOLUNTEER ASSISTANTS LIABLE FOR DAMAGES, LOSSES, OR INJURIES TO THE PERSON NAMED ON THE FRONT OF THIS FORM. THE PARENTS/GUARDIANS UNDERSTAND THAT THEY ARE SIGNING FOR THE MINOR LISTED AND SIGNATURE IS FOR BOTH A MEDICAL AND LIABILITY RELEASE.

THIS HEALTH HISTORY IS CORRECT, SO FAR AS I KNOW. IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY DURING THE DATES SPECIFIED ON THIS FORM, I HEREBY GIVE MY PERMISSION TO THE PHYSICIAN OR DENTIST SELECTED BY THE CHURCH LEADERSHIP OF FIRST BAPTIST CHURCH OF ASHLAND TO HOSPITALIZE, SECURE PROPER TREATMENT, AND/OR TO ORDER AN INJECTION, ANESTHESIA, OR SURGERY FOR MY CHILD AS DEEMED NECESSARY. I REALIZE THAT I WILL BE CONTACTED AT THE EARLIEST POSSIBLE MOMENT IN CASE OF SUCH AN EMERGENCY.

NOTE: IF **ALL** INFORMATION IS CURRENT FROM LAST YEAR, YOU MAY CHECK THE APPROPRIATE YEAR BOX AND SIGN. IF YOU HAVE NEW INFORMATION, PLEASE FILL OUT A NEW MEDICAL RELEASE.

☐ SEPTEMBER 1, 2016 – SEPTEMBER 1, 2017 PARENT SIGNATURE ______________________________

☐ SEPTEMBER 1, 2017 – SEPTEMBER 1, 2018 PARENT SIGNATURE ______________________________

☐ SEPTEMBER 1, 2018 – SEPTEMBER 1, 2019 PARENT SIGNATURE ______________________________

☐ SEPTEMBER 1, 2019 – SEPTEMBER 1, 2020 PARENT SIGNATURE ______________________________