Student Medical Release Form 2027

FBC Paris

Name: _____ Shirt Size: _____

Gender: Male Female Birth date: _____ Age: _____ Grade: _____

Email: _____ Cell phone: _____

Home address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian name: _____

Relationship to student: _____

Cell phone _____ Email: _____

Home Address _____ City _____ State ____ Zip _____

Parent/Guardian name: _____

Relationship to student: _____

Cell phone _____ Email: _____

Home Address _____ City _____ State ____ Zip _____

If the above are unavailable during emergency, contact: _____

Relationship to student: _____

Email: _____ Cell phone _____

Home Address _____ City _____ State ____ Zip _____

Does the student have any of the following allergies?

Latex	Yes	No	Penicillin	Yes	No
Insect Stings	Yes	No	Ivy Poisoning	Yes	No
Other Drugs	Yes	No	Hay Fever	Yes	No

Other Nonfood Allergies: _____

Please list any food allergies or dietary restrictions (peanuts, milk etc.)

_____

Does the student have any medical or health problems/conditions, and or has he/she any type of chronic or recurring illnesses: Yes No

If yes, please describe: _____

_____

_____

I give permission to administer over the counter medications:

Advil/Motrin (ibuprofen)	Yes	No	Benadryl	Yes	No
Tylenol (acetaminophen)	Yes	No	Pepto-Bismol	Yes	No

Name of family physician: _____

Phone number: _____

Student's dentist (and orthodontist if applicable) _____ Phone: _____

Is the student currently taking medication Yes No If so, please state the medication

_____

If so, will the student be bringing the medication to the activity? Yes No

If yes, please indicate the dosage prescribed, and the reason for the medication.

_____

_____

Date of last tetanus shot: _____

Is there medical or hospitalization insurance which provides benefits to the student? Yes No

If yes, please complete:

Name of Insurance Company: _____

Address: _____

Phone Number: _____

Policy Holder's Full Name: _____

Policy Number: _____ Group Number: _____

I understand that, in the event my student requires medical or dental treatment while engaged in the activities either on or off campus at First Baptist Paris, reasonable efforts will be made to contact me; however, if I cannot be reached, I hereby consent and give permission to the ministry's sponsor, acting on behalf of the ministry with respect to the activity, as agent for me, to consent to any medical treatment deemed medically necessary, including but "not" limited to: x-ray examination; injection; anesthesia; medical, dental or surgical diagnosis and treatment; and hospital care and treatment advised and given by a licensed physician, surgeon, dentist, or registered nurse, either as an outpatient or in a hospital. I further agree to indemnify and hold harmless any medical professional or church leader from loss, claim, or liability who provides authorization, medical, or first aid treatment to my student as deemed appropriate. I also give permission to the treatment facility to surrender physical custody of my student to the sponsoring agent's representative after treatment has been provided. To the best of my knowledge, I have disclosed and listed above all medical allergies, medication being taken, medical problems/conditions and pertinent information for the student indicated on this medical consent form.

Parent or Guardian Signature_____

Print Full Name: _____ Date: _____