NettletonBaptist CHURCH

2023 Medical Release
(Family Form)

This form is required for any participant on any church sponsored trip, function or event. Please complete this form and return it to the trip coordinator by the deadline. Participants are only required to complete one **MEDICAL RELEASE FORM** per calendar year. If there are changes throughout the year, it is the participants responsibility to complete an updated form.

Family Name _____ Number of Participants _____

Address _____ City _____

State_____ Zip _____ Home Ph. _____ Cell Ph. _____

ICE (In Case of Emergency) Information Required for all Participants
Please List Someone Other than Parents or Guardians Participating in this Trip/Event

Name _____ Phone _____ Relationship to Participants _____

INSURANCE INFORMATION

Policyholder's Name _____ Provider _____

Provider Phone_____ Group No. _____ Policy No. _____

I authorize Nettleton Baptist Church through its trustees, officers, directors, employees, agents or representatives to render or obtain such emergency medical care or treatment for me as may be necessary should any injury, harm or accident occur to me while participating in church sponsored activities.

_____ _____
Parent / Guardian Signature #1 (Participant) Date

_____ _____
Parent / Guardian Signature #2 (Participant) Date

Parent / Guardian Waiver for Minors (under 18 years old)

As the parent or legal guardian of the minor child I do consent to any medical, surgical, x-ray, anesthetic, or dental treatment that may be deemed necessary for the care and protection of my minor child / student while under Nettleton Baptist Church's supervision. In case of accident or illness, I understand that my student will be taken to an appropriate medical facility for treatment. I understand that efforts will be made to contact me prior to treatment but in the event I cannot be reached in an emergency, I give permission to the church representative to make the decisions necessary for treatment. As parent or legal guardian, I understand that I am responsible for the health care decisions of my minor child and agree that my insurance plan is the primary plan to pay for the medical, dental, or hospital care or treatment that is given to my minor child.

Parent / Guardian Name _____ Cell Ph. _____

_____ _____
Parent/ Guardian Signature Date

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Participant Information

Please complete for each family member participating in this trip / event.

For all "YES' responses, please give details in the space provided below.

Participant Name	Age & DOB	Allergies (including food)	Medications	Health Conditions	Date of last tetanus	Insurance Policy No. (if different)
1.				No		
2.				No		
3.				No		
4.				No		
5.				No		
6.				No		

Primary Care Physician _____ Phone _____ Same for all participants? No

Health Conditions: If "Y" circled above, describe below. Primary Care Physician: If "N" circled above, provide below.

Please use the numbers on each line when referencing further details.

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