

**MEDICAL RELEASE FORM 2019  
FIRST BAPTIST CHURCH, RICHMOND, KY**

**(PLEASE PRINT)**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Age \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

**Emergency Contact Person:**

Parent/Guardian Name \_\_\_\_\_  
Address (if different from student) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Numbers: (H) (\_\_\_\_) \_\_\_\_\_ (W) (\_\_\_\_) \_\_\_\_\_ (C) (\_\_\_\_) \_\_\_\_\_

**Alternate Contact Person: (Use someone other than Parent/Guardian):**

Name \_\_\_\_\_  
Address (if different from student) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Numbers: (H) (\_\_\_\_) \_\_\_\_\_ (W) (\_\_\_\_) \_\_\_\_\_ (C) (\_\_\_\_) \_\_\_\_\_

If you have medical insurance, you or your carrier will be billed for medical charges in the case of illness or injury while your child is at the activity. **If you do not have insurance you will be billed.**

Do you have health insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Name of Insurance Co. \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
In whose name is the insurance? \_\_\_\_\_  
Family Physician \_\_\_\_\_ City \_\_\_\_\_  
Physician Phone Number (\_\_\_\_) \_\_\_\_\_



*(Please turn over and complete the Health History.)*

**(1)**

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Page 2

If your child should require medical attention for injuries received or illnesses contracted prior to activity, please send us the necessary information to give him/her proper medical care during his/her time with the youth ministry activity. If they are currently on medication we ask that they NOT stop taking that medication while on a youth ministry activity.

**Health History:**

Pre-existing or present medical conditions \_\_\_\_\_

Name and dosage of any medications that must be taken \_\_\_\_\_

Any allergies? \_\_\_\_\_ To medications? \_\_\_\_\_

\_\_\_\_ Hay Fever                      \_\_\_\_ Heart Condition      \_\_\_\_ Diabetes                      \_\_\_\_ Insect Stings

\_\_\_\_ Epilepsy/Nervous Disorders      \_\_\_\_ Asthma                      \_\_\_\_ Frequent Stomach Upsets

\_\_\_\_ Physical Handicap                      \_\_\_\_ Other \_\_\_\_\_

\_\_\_\_ Any major illnesses during the past year?

If any of the above are checked, please give details (i.e., include normal treatment of allergic reactions)

Date of Last Tetanus Shot \_\_\_\_\_ Contact Lenses? \_\_\_\_\_

Any activity restrictions? \_\_\_\_\_ Yes \_\_\_\_\_ No

What? \_\_\_\_\_

**Please use the remaining page to give any other pertinent information to us.**

