2016-2017 First Baptist Hanford
Medical Release Form

PLEASE PRINT

Today's Date: ____________________________

Participant: ____ Child/Jr. High/HS/Adult (circle one)

Address: ___________________________________ City: _______________ Zip: _______________

Birthdate ____________________________ Sex: M _____ F _____ Grade (in fall of 2016) ______

Allergies/medications/medical conditions:____

____

Participant: ____ Child/Jr. High/HS/Adult (circle one)

Address: ___________________________________ City: _______________ Zip: _______________

Birthdate ____________________________ Sex: M _____ F _____ Grade (in fall of 2016) ______

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Address: ___________________________________ City: _______________ Zip: _______________

Birthdate ____________________________ Sex: M _____ F _____ Grade (in fall of 2016) ______

Allergies/medications/medical conditions: ____

____

CONTACT INFORMATION

Parent/Legal Guardian: ____
(if minor)

Address: ___________________________________ City: _________________ Zip:_____________

Home Phone _________________ Work Phone: _______________ Cell Phone: _________________

Parent/Legal Guardian: ____
(if minor)

Address: ___________________________________ City: _________________ Zip:_____________

Home Phone _________________ Work Phone: _______________ Cell Phone: _________________

Additional Emergency Contact: __________________________________ Phone:____________________

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PLEASE COMPLETE & SIGN BACK SIDE OF FORM

PARTICIPATION & MEDICAL RELEASE

I/we give permission for the above named individual(s) to participate in First Baptist Hanford activities. In the event of an emergency, I understand that an attempt will be made to contact me first. However, if I am unavailable, I authorize First Baptist Hanford and its agents and employees to authorize any and all necessary and appropriate medical treatment for the above named individual(s) for any injuries or conditions suffered by them in connection with said emergency, and I give permission to the attending physician to hospitalize, secure proper treatment and to order the administration of injections, anesthesia or surgery. (Note: Specify any forms of treatment, procedures or medications you do not authorize for the individual(s) indicated above.) I understand this medical release will remain in effect for all FBH activities through the end of May 2016. After that, a new release must be submitted for the current year.

Physician:_____ Phone:_____

Participant or Parent/Legal Guardian Signature: _____ Date: _____
Insurance Carrier: _____ Group/Policy #: _____

Revised: September 12, 2016
FBH Form #002