Medical Information, Authorization and Release of Liability

Springhill Baptist Church

Name____Birth date_________________
Minor's Parents____
Address____
Home Phone___________________________Work Phone____________________________
Relative or friend who may be contacted in the event you can't be reached:
____Phone____________________
Doctor's Name______________________________________Phone____________________

Check if you have any of the following medical conditions:

______Food Allergies (list:____)
______Asthma (list medications:____)
______Drug medication allergies (list:____)
______Nose or eye (Sinus) (list medications:_________________________________)
______Severe Reaction to insect bites/stings (types:__________________________)

Do you have heart problems or an irregular heart beat?

______Yes ______No If "Yes," please explain:_____________________________________
____
____

Do you have nosebleeds often?

______Yes ______No

Do you have any reoccurring ear problems, throat infections or swollen glands?

______Yes ______No If "Yes," please explain:_____________________________________
____
____

Do you have any other medical conditions, prior illnesses or injuries we need to be aware of?

______Yes ______No If "Yes," please explain:_____________________________________
____
____

Do you have any condition that would prevent you from participation in activities that require exercise or competition?

______Yes ______No If "Yes," please explain:_____________________________________
____
____

<u>To be completed by the parents of minor child:</u>

While your child is away from home with Springhill Baptist Church…

May we give him/her Tylenol or Ibuprofen if he/she has a headache or significant body ache?

Yes____ No____

May we give him/her Pepto Bismol, a similar medicine, or any anti-diarrhea medicine if he/she has an upset stomach or diarrhea?

Yes____ No____

If your child gets a cut which we believe needs more than a bandage, do we have permission to take him/her to a doctor or hospital for them to examine him/her and give him/her proper medical treatment, including but not limited to shots and stitches?

Yes____ No____

I give my permission for the above procedures and treatment.

________________________________ ____________
Signature of Parent/Guardian Date

Do you have medical insurance? ______Yes ______No

<u>Please attach a copy of your health insurance card.</u>

Name of Company____

Policy Number____

I hereby authorize any of Springhill Baptist Church's authorized agents, including but not limited to Fred Shackelford, Kim Allen, Eddie Allen, Kathy Steele, ______________________ ____________________________, ____ and ____to provide normal parental medical care to my child in my absence. I hereby authorize these individuals to have my child examined and treated by medical personnel, doctors and facilities of their sole choosing and to give their informed consent to any medical exam or treatment they determine is in my child's best interests. I hereby release the above individuals, physicians and medical facilities from any liability based solely on treating my child pursuant to this authorization. I understand that I will be notified, as soon as is reasonably practicable, should my child need to see a doctor. I hereby ratify the decisions and actions of the above individuals as though they were my own.

____
Signature of Parent

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