

**West Heights Baptist Church**  
**Dec. 31<sup>st</sup>, 2021– Dec. 31<sup>st</sup>, 2022**  
**MEDICAL RELEASE FORM**

**PERSONAL INFORMATION**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE (        ) \_\_\_\_\_ GRADE IN OR JUST COMPLETED \_\_\_\_\_

FULL NAME OF PARENTS: (If divorced, who is managing conservator?) \_\_\_\_\_

MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_

STEP-PARENT WITH WHOM CHILD ALSO LIVES: \_\_\_\_\_

MOTHER'S INFORMATION:

FATHER'S INFORMATION

EMPLOYER: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PH: \_\_\_\_\_

HOME PH: \_\_\_\_\_

BUS PH \_\_\_\_\_

BUS PH: \_\_\_\_\_

CELL PH \_\_\_\_\_

CELL PH: \_\_\_\_\_

**EMERGENCY NAMES AND NUMBERS IF PARENTS CANNOT BE REACHED**

1. \_\_\_\_\_ (        ) \_\_\_\_\_

2. \_\_\_\_\_ (        ) \_\_\_\_\_

**MEDICAL INFORMATION**

DATE OF LAST TETNUS SHOT: \_\_\_\_\_

ALLERGIES TO MEDICATIONS, INSECT BITES OR FOODS: \_\_\_\_\_

MEDICATIONS & CONDITIONS FOR WHICH MEDICATION IS TO BE ADMINISTERED: \_\_\_\_\_

OTHER MEDICAL CONDITIONS OR IMPORTANT INFORMATION: \_\_\_\_\_

**INSURANCE INFORMATION**

INSURANCE COMPANY \_\_\_\_\_

FULL ADDRESS \_\_\_\_\_

PHONE NUMBER (        ) \_\_\_\_\_ EMPLOYER \_\_\_\_\_

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

MEMBER NUMBER \_\_\_\_\_ ID NUMBER \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_

\*PLEASE NOTE THAT IT IS THE RESPONSIBILITY OF EACH PARENT OR GUARDIAN TO UPDATE THIS INFORMATION AS THE NEED ARISES.

**PLEASE COMPLETE PARENTAL CONSENT FORM AND HAVE NOTARIZED ON REVERSE SIDE.**

To Whom It May Concern:

The undersigned does hereby give permission for our (my) child, \_\_\_\_\_, to attend and participate in activities sponsored by West Heights Baptist Church (hereafter "WHBC"), which may involve travel in vans, buses or private vehicles. This authorization shall be effective continuously from the date hereof until canceled by written notice of WHBC.

We (I) authorize WHBC staff, employees, drivers, sponsors and helpers, in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provision of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization. Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

I hereby release WHBC, its staff, employees, drivers, sponsors and helpers from any liability for injury or damages suffered by the above child and agree to release, indemnify and waive any rights by subrogation I may have, and hold harmless WHBC, its staff, employees, drivers, sponsors and helpers for injury or damages to my child I/We have read and understand the above document. By signing this document, we hereby release WHBC from any and all liability for personal injury or damage to property.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**PHOTO/VIDEO RELEASE**

I give my consent to West Heights Baptist Church that my child, \_\_\_\_\_, may be photographed and/or video-taped during church affiliated activities. The photos, videos, and/or stories may be used in connection with any work of WHBC and release WHBC from any claims that may arise with regard thereto.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**Acknowledgment of Individual**

STATE OF MISSISSIPPI

COUNTY OF \_\_\_\_\_

Personally appeared before me, the undersigned authority in and for said county and state, on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, within my jurisdiction, the within named \_\_\_\_\_, who acknowledged that (he/she/they) executed the above and foregoing instrument.

\_\_\_\_\_

Notary Public

Printed Name: \_\_\_\_\_

My Commission Expires:

\_\_\_\_\_

**PLEASE COMPLETE PERSONAL AND MEDICAL INFORMATION ON REVERSE SIDE**