HOCUTT BAPTIST MEDICAL RELEASE

Name: _____ DOB: _____ GRADE:_____

Address: _____

Phone #: _____ Cell #: _____

Parent's Names: _____

Email Address: _____ Tee-Shirt Size: _____

In an emergency, please contact: _____

Relationship to you: _____ Phone # _____ Phone # _____

Primary Physician: _____ Phone # _____

Dentist: _____ Phone # _____

MEDICAL INFORMATION

List all known Medical Conditions:

_____

Daily Medication (Prescription or OTC) – List name and dosage amount:

_____

Food or Drug Allergies:

_____

Insurance Carrier: _____

Primary Insured Name: _____ DOB: _____

Policy # _____ Group #_____

In the event of an emergency or non-emergency situation requiring medical treatment, I hereby grant permission for any and all medical and/or dental attention to be administered to me/my child, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

PHOTOGRAPHIC AND VIDEO RELEASE

I hereby give Hocutt Baptist Church, including its volunteers, employees and any other persons and entities acting with its permission, or upon its authority, the absolute right and permission to take, copyright, use, and publish any photographs or video of or concerning my child for the purpose of any HOCUTT BAPTIST CHURCH advertising, education, promotion, or other purpose consistent with the HOCUTT BAPTIST CHURCH mission.

I agree that any such photograph or video is the exclusive property of the Hocutt Baptist Church, and I hereby waive all rights thereto. I further waive any and all rights to inspect and/or approve any printed or electronic material that may be used in conjunction with the photographs or video, or to approve the use to which the photographs or video may be applied.

PLEASE COMPLE OTHER SIDE. FORM MUST BE NOTORIZED

INSURANCE DISCLAIMER

Hocutt Baptist Church does not carry health or accident insurance on its members or participants. All expenses incurred in the treatment of illness, injuries or accidents will be the responsibility of the participant and his/her parents.

I have read, understand and accept the above conditions.

Signature: _____ Dated: _____

NOTORIZATION:

On this _____ day of _____, 20___, (name) _____

personally appeared before me in _____ County (in the state of _____),

and in my presence, signed this medical release form.

Name of Notary Official: _____

Signature: _____

Commission Expires: _____

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD TO THIS FORM