# MEDICAL RELEASE FORM

**All boys and teens 17 and under attending this activity *without* a parent/ guardian will need to fill out a signed medical release form.**

Name: ___________________________________________ Age: _____ Birth Date: ___/___/___

Address: ______________________________________________________________________

City: ______________________________________ State: _____________ Zip: ______________

Parent/Guardian Name: __________________________________________________________

Home Phone: (_____) _____-_________ Cell Phone: (_____) _____-_________

### HEALTH HISTORY

- ❒ Asthma
- ❒ Bleeding/Clotting Disorder
- ❒ Convulsions
- ❒ Diabetes
- ❒ Epilepsy
- ❒ Heart defect/disease
- ❒ Frequent ear infections
- ❒ Hypertension
- ❒ Mononucleosis
- ❒ Tetanus booster (or DPT)

**Allergies**

- ❒ Hay Fever
- ❒ Insect Stings
- ❒ Penicillin
- ❒ Foods (specify: ________________)
- ❒ Other (specify: ________________)

Does your child have any other ongoing health problems about which we should know?

_____________________________________________________________________________

Emergency Information: Health Insurance? ❒Yes ❒No

Insurance Company: _____________________________ Policy Number:________________

Physician: ______________________________ Physician's Phone: (_____) _____-_________

I hereby grant permission for my child to attend Camp of the Woods. I also grant permission to a recognized First Baptist Church staff member to act for me according to their best judgment in any emergency requiring immediate medical attention until I can be contacted. I hereby waive and release First Baptist Church and its employees from any and all liability for any injuries incurred at the Camp of the Woods. I will be responsible for any and all costs of medical attention and treatment.

I also grant permission to a medical facility to treat my child in the event this becomes necessary. I have provided the necessary insurance information, and in the event that insurance will not cover the necessary treatment, I will be responsible for any and all costs of medical attention and treatment.

Parent/Guardian Signature: _______________________________________ Date: ____________