

# Salem Baptist Youth Ministry

Sept 1, 2009 – Aug 31, 2010 Annual Medical Permission & Release Form

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_ grade \_\_\_\_\_  
Home # \_\_\_\_\_ cell # \_\_\_\_\_ Do you want to receive text msgs? \_\_\_\_\_  
Email \_\_\_\_\_ Myspace/Facebook/Aim? \_\_\_\_\_  
Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mom/Guardian name \_\_\_\_\_ work # \_\_\_\_\_ cell # \_\_\_\_\_  
Email \_\_\_\_\_  
Dad/ Guardian name \_\_\_\_\_ work # \_\_\_\_\_ cell # \_\_\_\_\_  
Email \_\_\_\_\_

Member of Salem? \_\_\_\_\_ If not, are you a member of a church? \_\_\_\_\_ Where? \_\_\_\_\_

## Medical Information

***Please attach a copy front & back of insurance card.***

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_  
Family Physician \_\_\_\_\_ phone # \_\_\_\_\_  
Immunizations: Polio Booster \_\_\_\_\_ Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Tetanus \_\_\_\_\_  
Past History (please circle): Asthma Sinusitis Bronchitis Kidney Trouble Diabetes Heart Trouble  
Allergies \_\_\_\_\_  
Current Medication \_\_\_\_\_  
Other Information \_\_\_\_\_

### **Permission to Participate**

In giving my child, \_\_\_\_\_, permission to attend and participate in programs and events and any of their associated activities sponsored by the Youth Ministry of Salem Baptist Church, I the undersigned, shall assume any and all costs including transportation costs, should any arise or should it become necessary for my child to return home due to medical reasons or otherwise.

### **Medical Permission**

In case of emergency, illness or injury to my child, my permission is granted for the YOUTH MINISTER or another adult in charge to secure necessary medical attention as quickly as possible at the nearest medical facility and by a certified doctor or medical attendant who would be immediately available.

### **Release**

Realizing that all normal care and caution will be taken by the sponsors, I do hereby release and forever discharge the sponsors and Salem Baptist Church from any and all claims, demands, actions or cause of actions, past, present, or future arising out of any damage or injury to my child. I also agree to accept full responsibility for the payment of all medical bills incurred by my child as a result of any accident or emergency.

### **Signatures**

By signing on this dated, \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_ in the State of Tennessee and County of \_\_\_\_\_, I indicate that I have read, understand and agree to the statements above.

\_\_\_\_\_  
Printed name of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian

### **Notarization**

On this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_, the above signed personally known by me and appeared before me, \_\_\_\_\_, and in my presence executed the within and foregoing Annual Medical Permission & Release Form. My commission expires \_\_\_\_\_

Notary Public \_\_\_\_\_

Seal