

**Hephzibah Baptist Church**  
**Permission/Liability/Medical Release Form**

I/We, the undersigned, do agree that by allowing \_\_\_\_\_ to participate in scheduled and previously announced youth group outings, events, and activities during the calendar year beginning January 1, \_\_\_\_\_, and ending December 31, \_\_\_\_\_, I/we am/are giving my /our permission for him/her to do so.

I/We, the undersigned, understand that neither Hephzibah Baptist Church, nor its officers, nor its employees, nor its volunteers, nor its representatives carry medical and hospitalization insurance coverage that would provide benefits in conjunction with or in lieu of any personal insurance coverage for minor or adult participants in these outings, events, and activities.

Therefore, I/We, the undersigned, do agree to pay all costs and expenses incurred in connection with such medical and/or dental services rendered to the participating member of my/our family pursuant to this authorization.

Should it be necessary for a return home due to medical reasons or disciplinary reasons, I/We, the undersigned, do agree to assume all transportation costs.

I/We, the undersigned, do give my/our permission for the aforementioned participant to ride in any vehicle designated by Hephzibah Baptist Church's leadership, in whose care he/she has been entrusted, provided that proper safety restraints are in place.

I/We, the undersigned, further understand that in the event of a medical or dental emergency while engaged in this activity/outing/event, every reasonable effort will be made to contact me/us. Likewise, after reasonable efforts have been unsuccessful, every effort will be made to contact the listed emergency contact persons I/we have provided. If none of us can be reached, I/we hereby consent to any medical or dental treatment that might be required in an emergency situation under the supervision of a physician, surgeon, or dentist.

To the best of my/our knowledge, I/we have listed any known drug or food allergies and/or any recent or ongoing physical conditions that might affect participation in the events/outings/activities or might be significant in the event of an emergency. Likewise, I/we agree to update the leaders of any new conditions as they become known so as to keep this consent form updated for all church activities/events/outings.

SIGNATURE OF PARENT: \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE OF PARENT: \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE OF PARTICIPANT: \_\_\_\_\_ DATE: \_\_\_\_\_

NOTARY SEAL AND SIGNATURE:

My commission expires on \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Full Name of Participant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Email: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Circle: Male Female

Age: \_\_\_\_\_ Grade in School: \_\_\_\_\_ School You Attend: \_\_\_\_\_

Are You a Member of Any Church? Yes No Which Church? \_\_\_\_\_

**PARENT INFORMATION:**

Mother's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Mother's Place of Employment: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Father's Place of Employment: \_\_\_\_\_

**MEDICAL INFORMATION:**

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Last Tetanus Shot: \_\_\_\_\_ Last Physical: \_\_\_\_\_

Emergency Contact # 1: \_\_\_\_\_ Relationship to You? \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact # 2: \_\_\_\_\_ Relationship to You? \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

List any drug allergies you know of: \_\_\_\_\_

\_\_\_\_\_

List any food allergies you know of: \_\_\_\_\_

\_\_\_\_\_

List any ongoing medications: \_\_\_\_\_

\_\_\_\_\_

List any previous surgeries/hospitalizations and dates: \_\_\_\_\_

\_\_\_\_\_