

# Medical Release Form / Permission to Treat



First Baptist Church  
510 W Main St.  
Knoxville, TN 37902  
(865) 546-9661

## Personal Information:

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

SS # (optional): \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

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

## Emergency Contact Information:

Parent/Guardian: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

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

Secondary Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

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

## Insurance Information:

\*Attach a copy of your insurance card to this form.

Insurance Co.: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Cardholder: \_\_\_\_\_ Relationship to Cardholder: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone: (\_\_\_\_) \_\_\_\_\_

## Personal Medical Information:

Physician s Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Physical Limitations (Asthma, diabetes, allergies, etc.), and/or Special Instructions (Allergic to certain meds, rare blood type, wears contact lenses, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(White Form)

List ALL medication taken on a regular basis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all operations/serious injuries and dates within the past five (5) years:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The Health History is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted.

**Emergency Authorization** - I hereby give permission to medical personnel selected by the First Baptist Church Knoxville staff to order X-rays, routine tests, and treatment for myself.

In the event of an emergency and neither my primary contact nor secondary can be reached, I hereby give permission to the physician selected by the Authorized Agent to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery to myself as named above.

I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company. In addition, I have, and do hereby, release the church, its employees or agents from liability associated with participation in a church activity.

I understand that if I do not have medical insurance, I, as the parent or guardian, will be responsible for any medical expenses in the event of a sickness and/or injury.

I understand that there are risks involved in taking place in recreation activities and other activities related to participation in youth functions.

I grant my permission to the foregoing parties to use any photographs, motion pictures, recordings, or any other record of participation in children's functions for any legitimate purpose.

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

**The following should be completed by the notary witnessing parent/guardian's signature.**

The State of \_\_\_\_\_ the County of \_\_\_\_\_ before me, a Notary Public, on this day personally appeared \_\_\_\_\_ known to me (or proved to me on the oath of \_\_\_\_\_) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration therein expressed. Given under my hand and the seal of the office this \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_.

Notary Public, Signature \_\_\_\_\_

My commission expires the \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_.