THOMASVILLE ROAD BAPTIST CHURCH

3131 Thomasville Road
Tallahassee, Florida 32308
(850) 386-4288 Fax (850) 298-4254

MEDICAL RELEASE FORM – C

January 2022 – January 2023

PARTICIPANT'S NAME _____ GRADE _____ AGE _____ DATE OF BIRTH _____

PARENT/GUARDIAN _____ ADDRESS _____

CITY / STATE / ZIP _____

HOME PHONE _____ WORK PHONE _____ OTHER EMERGENCY PHONE(S) _____

EMAIL _____

FAMILY DOCTOR _____ ADDRESS _____ PHONE _____

EMERGENCY CONTACT PERSON _____ PHONE NUMBER _____

This is to release and hold harmless Thomasville Road Baptist Church and its ministers and staff from any and all responsibility or liability arising out of the participant's involvement in all children's ministry activities. In the absence of one of the participant's parents or guardians, Thomasville Road Baptist Church is authorized to administer first aid or to obtain any emergency first aid or medical care by any physician, hospital, or attendant which may be needed by the participant as a result of involvement in the activity. I agree to abide and be bound by such decisions or consents as made by Thomasville Road Baptist Church and do assume full financial responsibility for and agree to pay all expenses of such care. I further understand that by present Florida Law, if the participant is riding in a church vehicle which is involved in an accident he/she will be primarily covered by bodily injury under our family automobile policy.

I further agree that if my son or daughter creates a disciplinary problem, I will be responsible for all costs related to his/her early return. I understand my child may be photographed or videotaped during normal programs and activities. These photos/videos may be used in promotional materials, on social media posts, or on the TRBC website. I hereby grant my permission for such photographs/videos to be taken and used at the discretion of Thomasville Road Baptist Church. If there are extenuating circumstances or legal matters that prohibit my child from being photographed or videotaped, I understand I must notify, in writing, Nicole Curtis (nicolecurtis@thomasvilleroad.org).

SIGNATURE OF PARENT / GUARDIAN _____ DATE _____

NOTARY (Print Name) _____ MY COMMISSION EXPIRES _____

STATE OF FLORIDA, COUNTY OF: _____

The foregoing instrument was acknowledged before me the _____day of _____ 20_____, by

_____
(Name of Parent or Guardian)

Personally known _____ or produced I.D. _____ (Type of I.D._____)

_____ _____
Notary Signature Print/Type/Stamp Name of Notary
Notary Public State of Florida

(See back)

CHILDREN'S MEDICAL TREATMENT CONSENT FORM

NAME_____ **DATE OF BIRTH** _____

Address _____ Home Phone (_____) _____

City/State/Zip _____

Medical History _____

Drug Allergy(s) _____

Current Medications _____ Last Tetanus Shot _____

INSURANCE COMPANY NAME _____

Employer Group or Individual _____ in which parent's name? _____

Group # _____ Contract # _____

Mailing address for claims _____

City/State/Zip _____