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

MEDICAL RELEASE FORM – Y

January 2019 – January 2020

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

PARENT/GUARDIAN **ADDRESS**

CITY / STATE / ZIP

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

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 youth 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.

Photo Release: During youth activities your youth and any guests may be photographed or videoed while participating in youth events. Therefore, every guest, by participating in any youth activity, acknowledges and agrees that these photos and/or videos may be taken and used in promotional materials. Please notify your guests of this agreement.

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.

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)

MINOR CHILDREN MEDICAL TREATMENT CONSENT FORM

NAME _____ **DATE OF BIRTH** _____

Address _____ Home Phone (_____) _____

City/State/Zip _____

Medical History _____

Drug Allergy(s) _____

Current Medications _____ Last Tetanus Shot _____

FATHER'S NAME _____

email address_____

MOTHER'S NAME _____

email address _____

INSURANCE COMPANY NAME _____

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

Group # _____ Contract # _____

Mailing address for claims _____

City/State/Zip _____