Gloucester Point Baptist Church
Youth Emergency Medical Release and Permission Form

This form will be kept on file in the church office and may be used for special activities, events and outings. It will remain on file and valid for a period of one year. If there are any changes, please notify us immediately so that we can keep all information current. We are seeking medical records for all of the youth so that we can respond promptly to their needs in the event of a health or medical emergency. Thank you for your assistance.

Personal Information
Youth's Name:_________________________________ Date of Birth:_________________________________

Address: ______________________________________ Email:_______________________________________

State: ___________ Zip Code: _____________ Male: _______ Female: _______ Age: ______ Grade: _____

Contact Information
Parent / Guardian: ______________________________ Relation to Youth:______________________________

Home Phone: _____________ Work Phone: ____________ Cell Phone: ______________

Other Adult Contacts
Name: ____ Relation to Youth: _____________________________

Home Phone: _____________ Work Phone: ____________ Cell Phone: ______________

Name: ____ Relation to Youth: _____________________________

Home Phone: _____________ Work Phone: ____________ Cell Phone: ______________

Emergency Medical Information
Physician's Name: ____ Phone: ____________________________

Health Insurance Carrier: ____

Policy ID Number: ______________________________ Group Number: _________________________________

Name of Policyholder: ____

Date of Last Tetnaus Shot: ______________________ Current Medications: ____________________________

Allergies, Dietary Restrictions, Medical Conditions, Restrictions:
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Parental Permission
I give consent for my child, _______________, to participate in activities, events and outings sponsored by Gloucester Point Baptist Church. I understand that the church does not accept responsibility for any bodily injury or property damage incurred during my child's participation. I give permission for any emergency medical treatment to be performed by a licensed physician or hospital when deemed necessary or advisable to safeguard my child's health when I cannot be contacted. I agree to be responsible for any expenses not covered by my insurance which may be incurred as a result of an accident or medical emergency involving my child.

____________________________ ______________________________ _____________
Signature of Parent/Guardian Print Parent/Guardian Full Name Date