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# MEDICAL RELEASE FORM

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ City, Church Name \_\_\_\_\_  
Parent/Guardian Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Employed by \_\_\_\_\_  
Daytime Phone (\_\_\_\_) \_\_\_\_\_ Evening/Night Phone (\_\_\_\_) \_\_\_\_\_  
Are you currently taking medicine or treatment?  yes  no  
If yes, explain \_\_\_\_\_  
Have you been restricted from sports or swimming for any reason?  yes  no  
If yes, explain \_\_\_\_\_  
Date of last Tetanus Toxoid Immunization: Month \_\_\_\_\_ Year \_\_\_\_\_  
Have you ever had a severe reaction to a bee/hornet sting, or insect bite?  yes  no  
If yes, explain \_\_\_\_\_

<b><u>Do you have:</u></b>	<b><u>List any Allergies:</u></b>
<input type="checkbox"/> Sinus Trouble	Food _____
<input type="checkbox"/> Hay Fever	_____
<input type="checkbox"/> Heart Trouble	Drugs _____
<input type="checkbox"/> Epilepsy	_____
<input type="checkbox"/> Asthma	Other Medical Needs: _____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Communicable diseases? If yes, please explain _____	_____
_____	_____

NOTARY SPACE

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# EMERGENCY MEDICAL AUTHORIZATION

Event: Eagle Retreat 2019

In the event of an emergency, I hereby give permission to the appointed sponsor who is with my child or to any Kansas-Nebraska Convention of Southern Baptists staff person, or their designee, who is present at the above-mentioned event to obtain medical assistance for my child. I also give permission to the Physician selected to hospitalize and secure proper treatment for my child.



Parent/Guardian Signature \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Mailing Address to Submit Claims: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy Number \_\_\_\_\_  
If I cannot be reached, please notify \_\_\_\_\_  
(\_\_\_\_) \_\_\_\_\_ or (\_\_\_\_) \_\_\_\_\_  
Today's Date \_\_\_\_\_

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