

**Eastridge Baptist Church
YOUTH MINISTRY
Emergency Medical Release Form**

1. I, the undersigned, parent/legal guardian of _____, a minor, do hereby authorize any adult person in whose care the said person has been entrusted by Eastridge Baptist Church, to consent to any diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician and/or surgeon or dentist. It is understood that this authorization is given in advance of any specific care being required.
2. I hereby give my permission to the physician, nurse, or dentist selected by Eastridge Baptist Church to secure medical or dental aid as required for illness or injury under a physician's orders, including transportation to and from necessary facilities. I understand that Eastridge Baptist Church is not obligated to carry any insurance to cover those expenses in excess of the limits of the participant's insurance. I understand that my personal insurance is my primary coverage.
3. I hereby authorize any hospital or dentist which has provided treatment to the above named person to surrender physical custody of such person to the above named agent upon completion of treatment.
4. I do hereby release Eastridge Baptist Church, its officers, employees, agents, and members of the Board of Elders from all claims and causes of action by reason of any injury that may be sustained as a result of these church activities, whether on the church premises or on the way to or from these activities.
5. This authorization shall remain effective until revoked in writing delivered to Eastridge Baptist Church.
6. We also give our consent to Eastridge Baptist Church to photograph the above named person and, without limitation, to use such pictures and/or stories in connection with any work of Eastridge Baptist Church and do hereby release Eastridge Baptist Church from any claims whatsoever that may arise with regard thereto.

Signature of parent/legal guardian _____ Date _____

Family Physician _____ Phone _____

Medical Insurance Carrier _____ Policy/ID # _____

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STUDENT INFORMATION:

Name _____ Birthdate _____

Address _____ Phone _____

School _____ Grade _____

PARENT/GUARDIAN INFORMATION:

Name _____ Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

EMERGENCY CONTACT (if parents/legal guardian or care-giver cannot be reached):

Name _____ Relationship _____

Address _____ Phone _____

MEDICAL INFORMATION:

Please check and explain if any past history of:

- | | | | | |
|---|--|--|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy or other nervous disorder | <input type="checkbox"/> Stomach upsets or disorders | <input type="checkbox"/> Other (explain below) | | |

Comments/Additional Information (include prescription medications):

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