



**Contact Information/Medical Permission & Release Form**

**June 1, 2009 - August 31, 2010**

I fully realize that any activity involves a risk of personal injury, property damage, or loss of my person or property. I hereby for myself, my heirs, executors, and administrators, waive and release any claims or rights against Wakefield Baptist Church, all of its officers, directors, and coordinators, all owners of equipment which may be used and those who volunteered their equipment, vehicles, and services for any church activity, for any and all injury, damage, or loss to my person or property incurred during a church sponsored activity.

It is my understanding that Wakefield Baptist Church will attempt to notify me in case of a medical emergency involving my child. If Wakefield Baptist Church staff members, chaperones, or any other Wakefield leaders cannot reach me, then I authorize Wakefield Baptist Church to secure any medical treatment necessary for my child by any licensed physician or dentist, including the admission for such emergency care to any hospital reasonably accessible. This authorization does not include major surgery unless two licensed physicians or dentists concur that immediate surgery is necessary. I give my permission to the doctor or other health-care professional to provide the medical services he or she may deem necessary. I will accept responsibility for medical expenses so incurred.

**(Please print clearly)**

Child's Name: \_\_\_\_\_ Parent/Legal Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City Zip

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Legal Guardian Telephone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Contact in case of Emergency (Relationship): \_\_\_\_\_

Contact's Telephone Number: \_\_\_\_\_

Secondary Contact in case of Emergency (Relationship): \_\_\_\_\_

Secondary Contact's Telephone Number: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Any Medical Problems? Yes \_\_\_ No \_\_\_

If yes, describe: \_\_\_\_\_

Medications Currently Prescribed? Yes \_\_\_ No \_\_\_

If yes, describe: \_\_\_\_\_

\_\_\_\_\_  
Parent / Legal Guardian Signature

\_\_\_\_\_  
Date