



**CROSSWALK**  
MINISTRIES

# For the calendar year 2016 Medical Release Form

(Please print)  
Name of student \_\_\_\_\_

Date of birth \_\_\_\_\_

Address \_\_\_\_\_ Age \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

M  F  Height \_\_\_\_\_ Weight \_\_\_\_\_

### **Emergency Contact Person:**

Parent/Guardian Name \_\_\_\_\_

Email \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Address (if different from student) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

### **Alternate Contact Person:** (Use someone near the primary contact)

Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_ Email \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while your child is at the activity. Do you have health insurance? Yes  No

Name of Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

In whose name is the insurance? \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ City \_\_\_\_\_

If your child should require medical attention for injuries received or illnesses contracted prior to activity, please send us the necessary information to give him/her proper medical care during his/her time with the youth ministry activity.

**Please see reverse side**

**Health History:**

Pre-existing or present medical conditions      Yes       No

If yes, please explain \_\_\_\_\_

Name and dosage of any medications that must be taken \_\_\_\_\_

Any allergies? \_\_\_\_\_ To medications? \_\_\_\_\_

\_\_\_\_\_ Hay Fever \_\_\_\_\_ Heart Conditions \_\_\_\_\_ Diabetes \_\_\_\_\_ Insect stings \_\_\_\_\_ Epilepsy \_\_\_\_\_ Asthma

\_\_\_\_\_ Frequent Stomach upsets \_\_\_\_\_ Physical Handicap \_\_\_\_\_ Any major illnesses in the past year?

If any of the above are checked, please give details (i.e., included normal treatment of allergic reactions)

Date of last Tetanus shot \_\_\_\_\_ Contact lenses? \_\_\_\_\_ Swimming restrictions? \_\_\_\_\_

What? \_\_\_\_\_

Any activity restrictions? \_\_\_\_\_ What? \_\_\_\_\_

**Medical and Liability Release Statement:**

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I cannot be reached in an emergency during the activity date shown on the permission form, I hereby give my permission to the physician or dentist selected by the **Crosswalk Youth Staff** to hospitalize, to secure medical treatment and /or to order an injection, anesthesia , or surgery for my child as deemed necessary.

I understand that my insurance coverage for my child will be used a primary coverage in the event medical intervention is needed. Coverage by **Bethany Baptist Church** through its accident policy will be used as a backup for what my family's insurance does not cover.

I understand all reasonable safety precautions will be taken by the **Crosswalk Youth Staff** and its agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold **Bethany Baptist Church**, it's leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Student (if over 18 years of age) \_\_\_\_\_

**Crosswalk Youth Ministry is a ministry of  
Bethany Baptist Church  
1150 Hilfiker Lane SE  
Salem, OR 97302  
(503)362-2488**