CROSSWALK MINISTRIES

For the calendar year 2017
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
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Salem, OR 97302
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