



**PARKER MEMORIAL BAPTIST CHURCH
MEDICAL INFORMATION / RELEASE FORM 2021
ADULT / CHAPERONE**

Name: _____ Date of Birth: _____ Sex: M F
Phone #: __ (____) _____ Social Security #: _____
Street Address: _____
City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact #1

Emergency Contact #2

Relationship

Relationship

_(____) _____
Home Phone Work Phone

_(____) _____
Home Phone Work Phone

Address

Address

City, ST ZIP Code

City, ST ZIP Code

MEDICAL INFORMATION

Family Physician: _____ Phone #: _____

Hospital / Clinic Preference: _____

Address: _____

Insurance Company: _____ ☐ Ins Card on file in church office

Policy Number: _____ Contract Number: _____

Name of Insured: _____ Social Security # of Insured: _____

Do you have any medical problems we should know about if medical treatment should become necessary?

Please list any medication you take on a regular basis or are now taking:

Is there any other medical information you feel we should know about you?

If so, please explain: _____

RELEASES AND CONSENT

I understand this form will include all trips during the 2021 year's activities and covers recreational and other physical activities.

Medical Release: I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for myself and waive my right to informed consent of treatment.

Signature

Date

Liability Release: In consideration for the privilege of being allowed to participate in trips and activities, I agree to release and hold harmless Parker Memorial Baptist Church, its officers and agents, from any liability to or responsibility for bodily injury, damage or illness to myself while participating, including transportation to and from the activity. Further, I agree to indemnify and hold harmless Parker Memorial Baptist Church, its officers and agents with respect to any claim asserted by or on behalf of myself as a result of bodily injury, illness, or damage.

Signature

Date

Witness Signature

Date