

FIRST BAPTIST CHURCH OF CHALKVILLE MEDICAL RELEASE AND CONSENT FORM

2100 Old Springville Road • Birmingham, Alabama • 35215-4031
(205) 854-1472 • (205) 856-3465 fax • fbcchalk@bellsouth.net • www.fbcchalkville.org

PARTICIPANT INFORMATION

First Baptist Church of Chalkville appreciates you sharing this important information and will respect its confidential nature.

NAME: _____ SEX: F M
LAST FIRST MIDDLE

HOME ADDRESS: _____ TEL. NO. (____) ____ - ____
NUMBER STREET

CITY STATE ZIP CODE

DATE OF BIRTH: ___/___/___ AGE: ____ SOCIAL SECURITY ____ - ____ - ____

NAME OF HOME CHURCH: FBCC OTHER: _____

PHONE NUMBER OF HOME CHURCH: FBCC OTHER: (____) ____ - ____

IN CASE OF AN EMERGENCY

Please contact:

NAME: _____ RELATIONSHIP: _____

HOME: (____) ____ - ____ BUSINESS: (____) ____ - ____ CELL: (____) ____ - ____

NAME: _____ RELATIONSHIP: _____

HOME: (____) ____ - ____ BUSINESS: (____) ____ - ____ CELL: (____) ____ - ____

HEALTH & HOSPITALIZATION INSURANCE INFORMATION

NAME OF INSURANCE: _____ POLICY NUMBER _____

****Please attach a copy of your driver's license and medical insurance card to this form****

NAME OF INSURED: _____ RELATIONSHIP _____

GROUP NUMBER: *(if any)* _____ COVERAGE CODE: *(if any)* _____

INSURANCE COSTUMER SERVICE NUMBER/PRE-CERTICATION NUMBER: (____) ____ - ____

Participant's Name _____

NAME OF PHYSICIAN: _____ PHONE (____) ____ - ____

NAME OF DENTIST: _____ PHONE (____) ____ - ____

REPORT OF MEDICAL HISTORY

Personal History: *(Please check if your child has had or are currently being treated for any of the following)*

- | | | |
|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glasses/Contact Lenses | <input type="checkbox"/> Migraine/Frequent |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hearing Aid(s) | <input type="checkbox"/> Severe Headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problem/Murmur | <input type="checkbox"/> Physical Handicap |
| <input type="checkbox"/> Back Problem | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Insect Allergies | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung Problem | <input type="checkbox"/> Unexplained Aches |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> and Pains |
| | <input type="checkbox"/> Kidney Problems | |

LIST OF PERSCRIPTION MEDICATIONS

NAME	DOSAGE	X/DAY	NAME	DOSAGE	X/DAY

Can your child be given the following medications by a church representative or staff member?

Aspirin? Yes No **Acetaminophen?** Yes No **Ibuprofen?** Yes No
Medications on your provided list? Yes No

Other medical conditions, that your child has, you believe we should be aware of? *(Please explain)*

Participant's Name _____

List any allergies:

GOOD HEALTH ACKNOWLEDGEMENT

I hereby certify that my child is in good health and that all information that I have provided on this form is correct. I also certify that he/she can travel to and participate in all functions of the First Baptist Church of Chalkville. I understand that it is my responsibility to keep all information on this form updated (*including my medical history*) by contacting the church office.

PARENT/LEGAL GUARDIAN SIGNATURE

DATE

WAIVER OF LIABILITY/AUTHORIZATION FOR TREATMENT

I, _____, the undersigned parent or legal guardian, do hereby release and discharge the First Baptist Church of Chalkville of Birmingham, Alabama and its authorized representatives and staff from all liability of any kind and character upon any claim, demand or cause of action which might be asserted on my child's behalf against said church representatives or staff. Furthermore, in the event of an emergency and/or accident, if the said staff and representatives are unable to contact the emergency contact that I have provided, I do authorize the First Baptist Church of Chalkville of Birmingham, Alabama and its authorized representatives and staff to consent to any x-ray, examination, medical, surgical or dental diagnosis or treatment and hospital care to be provided to my child under general or special supervision and upon the advice of a physician, surgeon, or dentist licensed to practice medicine.

In giving this consent I recognize and understand that in situations where my child should require immediate medical or available alternative treatments or procedures, if any, or to evaluate the risk attendant upon the same, and the risk of attendant to foregoing all treatments; in such situation, I hereby authorize a physician, surgeon or dentist to exercise professional judgment and to evaluate the risks involved and to select the necessary treatment from any available alternatives and to provide such care and perform such treatment as that physician, surgeon or dentist in his professional judgment deems necessary to assure my health and safety.

PARENT/GUARDIAN SIGNATURE _____ DATE ___/___/_____

NOTARY PUBLIC*

On this date, ___/___/____, the person signed above personally appeared before me, being personally known by me, and in my presence executed this authorization and release form. Witness my hand and official seal:

_____ Notary Public

My commission expires: ___/___/_____

**Notary Services are available free of charge at First Baptist Church of Chalkville. Please call the church office for more information.*