

**First Baptist Church**  
**Vivian, LA**  
311 North Pine, Vivian, LA 71082

**Medical Release and Emergency Information**  
**Youth Ministry**

Name: \_\_\_\_\_ Birthday: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City, State & Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

In the event that \_\_\_\_\_ becomes ill or sustains an injury while participating in or traveling to or from an authorized and chaperoned church event with First Baptist Church, Vivian, Louisiana, I, the undersigned, give my permission to those in charge to take whatever steps are necessary to stop any bleeding and/or administer first aid. I also consent to x-ray examinations, anesthetic, medical, dental, or surgical diagnosis and treatment, including invasive procedures and hospital care as well as the administration of drugs or medicine to be rendered to my son/daughter under my legal watch care, under the general or specialized supervision and upon the advice of a duly licensed physician and/or surgeon.

I release the church, its employees, its representatives, its volunteers, and/or sponsors from liability for accidental injuries on these trips or activities.

I assume all responsibility for any medical and emergency expenses associated with any accident, injury, or other incapacity, regardless of whether I have authorized such expenses.

I further understand and agree that, in the event that the above named son/daughter be involved in any non-Christian or dangerous activities, I will pay his or her expenses to be sent home immediately at the discretion of the approved sponsors and/or church representatives.

**I understand that this consent will apply in ALL emergency situations PRESENT and FUTURE and will remain in effect until written revocation is received by certified United States Mail.**

I understand that I must notify First Baptist Church, Vivian, Louisiana at the point where my medical information changes.

I understand that I must get this Release for Notarized by an official Notary.

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date Signed

**Insurance Policy Number** \_\_\_\_\_ **Group Policy Number** \_\_\_\_\_

**Group Policy With** \_\_\_\_\_ **Coverage Phone Number** \_\_\_\_\_

**Doctor's Name and Phone Number** \_\_\_\_\_

**Current Medications** \_\_\_\_\_

**List any medical, physical, or other limitations** \_\_\_\_\_

\_\_\_\_\_

**Date of Last Tetanus Shot** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
**Notary Signature**

\_\_\_\_\_  
**Notary Identification Number**

**Date Notarized** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_