

**FIRST BAPTIST CHURCH – 915 E Sugnet Rd – Midland, MI 48642 – 989.835.6731**  
**REGISTRATION / INFORMATION / PERMISSION / MEDICAL TREATMENT FORM**  
**2023 - 2024**

**1<sup>st</sup> Minor's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Grade:** \_\_\_\_\_ **Sex:** M or F **School Attending:** \_\_\_\_\_

**Student's Email Address:** \_\_\_\_\_

**2<sup>nd</sup> Minor's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Grade:** \_\_\_\_\_ **Sex:** M or F **School Attending:** \_\_\_\_\_

**Student's Email Address:** \_\_\_\_\_

\*Additional students may be listed on back of form

**Father's Name:** (Please Print) \_\_\_\_\_ **Contact Phone:** \_\_\_\_\_

**Mother's Name:** (Please Print) \_\_\_\_\_ **Contact Phone:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
(Street) (City) (Zip)

**E-Mail Contact:** \_\_\_\_\_

\*\*\*\*\*  
Please use the space below to let us know anything else that we should know about your student or anything you feel would help make your student's experience more enjoyable:  
\_\_\_\_\_  
\_\_\_\_\_

**Designated Pick-Up Person(s) for my student:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**OR**

I give my student permission to meet me at: \_\_\_\_\_ **Bicycle** \_\_\_\_\_ **Walk Home** \_\_\_\_\_

**Pictures/Videos may be taken of my minor student for FBC publicity purposes.** \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**

\_\_\_\_\_ may go on field trips/events sponsored by First Baptist Church.  
minor's name(s)

\*\*\*\*\*  
**Emergency Contacts:** (Please list Name & Relationship to Student)

1. \_\_\_\_\_ **Phone:** \_\_\_\_\_

2. \_\_\_\_\_ **Phone:** \_\_\_\_\_

**In the unlikely event that a medical emergency should arise for my minor, I hereby give my consent to the Leaders and Adult Sponsors of First Baptist Church (FBC), Midland, to secure emergency medical and surgical treatment, and to provide routine, non-surgical medical care for the minor named above, while participating in FBC activities. I understand that all effort will be made to contact me first.**

**Medical / Allergy Info:** (List allergies to Food, Medicine or Insect Bites, and any info pertinent to your student's safety, i.e. asthma, diabetes, seizures, etc.)

**Insurance Provider:** \_\_\_\_\_ **Insured:** \_\_\_\_\_  
Insurance Company Name Primary's Name

**Parent Printed Name:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Rev. 4-13-2023 (This form is good for one year from this date.)