



Medical Information and Release Form for -2024
Anastasia Baptist Church, 1650 A1A South, St. Augustine, Florida 32080

Name of Participating Child:		Age:	Birth Date:	
Address		City	State	Zip Code
Parent information:				
Email:		Home Phone		
Father (Guardian) Name:		Cell Phone:		
Mother(Guardian) Name:		Cell Phone:		
Hospital Insurance oYes oNo	Insurance Company	Policy Number		
Policy Holder		Group Number	Policy Holder Date of Birth	
Physician's Name:		Phone:		
In case of Emergency when parents are unreachable Notify:				
Name:		Phone:		

RELEVANT MEDICAL HISTORY

***In the past, or presently, the participant has been treated for, suffered from or engaged in:
Check where appropriate and supply any necessary additional information.***

<div>Asthma Asthma Medication Diabetes Insulin Dependent Kidney Trouble Heart Trouble Bronchitis, Sinusitis Stomach, Gastrointestinal Problems Dizziness Hearing Impaired Visually Impaired Childhood Diseases Mumps Chicken Pox Measles Whooping Cough Other: _____</div>	Please List Any:	Previous Surgeries:
	Allergies: Drug Allergies:: Food Allergies:: Insect Sensitivities:	Chronic Infectious Illness or Disease: Special Medical Information: Special Medications: Special Diet:
PLEASE LIST ANY/ALL MEDICATIONS _____ _____ _____		

I hereby authorize employees, representatives or authorized event leaders from Anastasia Baptist Church in whose care the minors named above have been entrusted to consent to appropriate and reasonable medical care as recommended by a treating medical doctor including but not limited to X-ray examination, anesthetic, medical, surgical diagnosis, treatment or hospital care, to be rendered by a duly licensed medical practitioner. The undersigned shall be fully liable to and agree to pay all costs and expenses in connection with such medical services rendered to the child.

This document will be considered valid during the time period beginning January 1, 2024 until December 31, 2024.

I hereby certify that the medical history provided on this document is correct. I understand that it is the duty of the parent/guardian to make any necessary additions to the medical history, if necessary.

Printed Name of Parent (Guardian) **X** _____
Signature of Parent (Guardian) **Date**

NOTARY CERTIFICATION

On this the ____ day of _____ of _____, the above person personally appeared before me _____
(Printed Name of Notary Public)
and in my presence executed the within and foregoing release form. Witness by my hand and official seal this _____ day of _____,
_____.
My commission expires _____ . Notary Public : _____