



**HOLLAND
CHAPEL**
BAPTIST
CHURCH

Authorization for Medical Aid and Release of Liability

Participant's Name _____
Social Security Number: _____ DOB: _____ Grade _____
Address: _____
Name of Parent or Guardian: _____
Home Phone: _____ Work: _____ Other _____

INSURANCE INFORMATION:

Name of Insured: _____ Policy Number _____
Name of Insurance Company _____

MEDICAL INFORMATION:

List any medicines that participant is allergic to: _____

List any allergies and treatment needed (hay fever, bee stings, etc): _____

List any other medical history of which Holland Chapel Baptist Church should be aware (fainting, seizures, asthma, dizziness, etc.): _____

List any and all medications participant would likely have in their possession at church functions and trips (This should be updated whenever necessary). _____

Physician who knows this participant best: _____ Phone: _____

RELEASE OF LIABILITY

1. Please list any activities in which you or your child is not to participate: _____
2. Holland Chapel Baptist Church including employees and representatives of the aforementioned organizations shall be held harmless from any suit, action, damages, or claims at law or otherwise, resulting from or arising out of any injury, accident, or illness which may befall (name of activity participant) _____ and / or his/her property while participating in Holland Chapel Baptist Church sponsored activities. If the participant is a minor this covenant is applicable to the afore signed and his/her parents or guardian.
3. The undersigned parent or guardian hereby authorizes sponsor, sponsor's agent, or employee to take such action as may be necessary for the medical care or treatment including the administration of medication, performing surgery, or such other action as needed in the event of injury or illness of participant when parent or guardian cannot be reached for authorization. In the event the above authorized refuse or are not able to act, Holland Chapel Baptist Church personnel are authorized to act as set forth above. This authorization may be presented to medical personnel to seek further authority.

(Signature of participant) (Date)

(Signature of parent / guardian if under 18) (Date)

**** This medical release is good for 1 year from the date of this document.**

Notary Public

On this the ____ day of _____, 20____, personally appeared before me _____,
and in my presence executed the within and foregoing permission and release form. Witness my hand and official seal this ____ day of _____, 20____. My commission expires _____.

Notary Public