

Tri-City Baptist Temple - MEDICAL RELEASE FORM

Date of Activity: _____ Purpose of Activity: _____ Person in charge of Activity: _____	Tri-City Baptist Temple PO Box 787 – 18025 Webster Rd. Gladstone, OR 97027 (503) 655-9326 www.tcbt.org
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(Please print or type)

Child's Name: _____ Age: _____ Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Parent or Guardian's Name: _____
Home Phone: _____ Work Phone: _____
Cell Phone #1: _____ Cell Phone #2: _____
Medical Insurance Company: _____ Policy Number: _____
Name of Policy Holder: _____ Date of last Tetanus booster: _____
Name of Family Physician: _____ Phone: _____
Name of Family Dentist: _____ Phone: _____
Please state any restrictions, physical impairments and necessary limitations of activities: _____

Please state any known allergies: _____
List any current prescription medications: _____
Pertinent medical history (i.e. diabetes, asthma, heart problems, seizures, etc.): _____

In the event that a parent/guardian cannot be reached, who should be called?

Name: _____
Relationship to Child: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____

I understand that photographs and videos of my child may be taken while at this activity/event and will allow them to be used in any TRI-CITY BAPTIST TEMPLE publications. I understand that publication of these photographs and videos may be accomplished in print or electronically via the internet, and that after publication the church will be unable to prevent persons from gaining access to and subsequently using, altering, or republishing them without my consent. I waive any claim for damages against the church from such use, alteration, or republication of these photographs and videos by third parties.

In case of an emergency, I understand that every effort will be made to contact me. However, if I cannot be reached, I hereby give permission to the physician or dentist selected by the church staff or sponsor to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child named above.

Signature of Parent/Guardian

Date