



# Summit Student Medical Release Form

VALID: JANUARY 1, 2017 - DECEMBER 31, 2017

McConnell Memorial Baptist Church, 84 Church St. Hiawassee, Georgia

Page 1 of 2 - All sections must be completed.

STUDENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_ / \_\_\_ / \_\_\_\_\_ GENDER: \_\_M \_\_ F

PARENT/GUARDIAN NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBERS: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_

(Other than a parent/guardian)

PHONE NUMBERS: \_\_\_\_\_

## AGREEMENT

The undersigned, as parent or guardian of the student listed above, hereby...

1. Authorizes any staff member and/or adult chaperone who may be supervising or directing any activity sponsored by McConnell Memorial Baptist Church, Hiawassee, Georgia, to authorize emergency medical treatment of the student named above while this person is participating in any trip or activity sponsored by McConnell Memorial Baptist Church, Hiawassee, Georgia.
2. Releases McConnell Memorial Baptist Church, its staff, employees, and sponsors from any liability for personal injury, damage, or loss that the student named above may sustain while participating in any activity sponsored by McConnell Memorial Baptist Church, Hiawassee, Georgia.
3. Agrees to be responsible for any costs that may be incurred in returning the student named above from any trip due to illness, injury, or misconduct.
4. Agrees that insurance and medical information provided on the next page is complete and accurate.
5. Agrees to provide updates to McConnell Memorial Baptist Church if there is any change in insurance or medical information.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (Over 18 years of age) Signature  
(Please complete other side as well)

\_\_\_\_\_  
Date



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Page 2 of 2 - Complete a new form if any information changes.

## INSURANCE INFORMATION

INSURED POLICY HOLDER NAME: \_\_\_\_\_

INSURANCE COMPANY

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

GROUP #: \_\_\_\_\_

POLICY #: \_\_\_\_\_

## STUDENT'S MEDICAL INFORMATION

LIST AND EXPLAIN ANY MEDICAL PROBLEMS (OR WRITE "None"):

LIST MEDICATIONS BEING TAKEN AND REASON FOR TAKING (OR WRITE "None"):

LIST ANY KNOWN ALLERGIES INCLUDING ENVIRONMENTAL, FOOD & MEDICATIONS (OR WRITE "NONE"):

DATE OF LAST TETANUS SHOT: \_\_\_\_\_