



# Medical Release Form/Permission to Treat

Name of Church: Katy's First Baptist Church City/State: Katy, TX  
 Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex (M/F): \_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
 Home Phone:(\_\_\_\_) \_\_\_\_\_ Work Phone:(\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
 Secondary Contact in event of emergency: \_\_\_\_\_  
 Relationship to you: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_  
 Medical Insurance Co.: \_\_\_\_\_ Group# \_\_\_\_\_ Policy#: \_\_\_\_\_ Company's Phone:(\_\_\_\_) \_\_\_\_\_  
 Company's address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

**Please attach a copy of your insurance card**

Family Physicians Name: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_

Food Allergies and/or special instructions:

Physical Limitations (Asthma, diabetes, allergies, etc.), and/or special instructions (Allergic to certain meds, rare blood type, wears contact lenses, etc.)

List ALL medication taken on a regular basis and/or any brought with you to Camp (Prescription meds MUST have a pharmacy label and name of doctor):

List all operations/serious injuries and dates within the past five (5) years:

**Emergency Authorization** - I hereby give permission to medical personnel selected by Katy's First Baptist Church, Group Sponsor or camp staff to order X-rays, routine tests, and treatment for myself. In the event of an emergency and neither my primary contact nor secondary can be reached, I hereby give permission to the physician selected by the Authorized Agent to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery to myself as named above. I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company. In addition, I have, and do hereby, release the church, its employees or agents from liability associated with participation in a church activity. I understand that if I do not have medical insurance, I, as the parent or guardian, will be responsible for any medical expenses in the event of a sickness and/or injury. I understand that there are risks involved in taking place in recreation activities and other activities related to participation in youth functions.

Signature of Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

**The following to be completed by the notary witnessing parent/guardians signature.**

The State of \_\_\_\_\_ County of \_\_\_\_\_ Before me, a Notary Public, on this day personally appeared \_\_\_\_\_ known to me to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration therein expressed. Given under my hand and the seal of the office this \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_.

Notary Public, Signature \_\_\_\_\_  
My commission expires the \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_.