

BROOKWOOD BAPTIST CHURCH

2010-2011 Family Medical Insurance Information & Release (Please include information for Children and Youth on this form)

THIS AUTHORIZATION RELEASE IS VALID JUNE 1, 2010 – JUNE 1, 2011.

Father's Full Name _____ Email _____

Father's Home Phone _____ Work Phone _____ Cell Phone _____

Mother's Full Name _____ Email _____

Mother's Home Phone _____ Work Phone _____ Cell Phone _____

Home Address _____ City, State, Zip _____

Family Doctor _____ Phone (_____) _____

Address _____

Emergency contact if parent(s) are not available:

Name _____ Address _____ Phone (_____) _____

I certify that the listed youth(s) is my child or my legal ward and resides with me. In the event he/she becomes ill, is injured, or for any reason requires medical treatment while attending a Brookwood Baptist Church function or activity, I do hereby consent to any and all medical or surgical treatment, including anesthesia and operations, which may be deemed advisable by any qualified physicians selected by agents or officials of Brookwood Baptist Church. In the event treatment is called for which a physician or other health care provider refuses to administer without my/our consent, I/we hereby authorize any Minister or staff, or any other reasonable adult accompanying the Children/Youth Ministry, or Brookwood Baptist Church to give such consent and further agree to hold any person harmless from any claims, demands or suits or any nature arising from the giving of such consent so long as the treatment is administered by or under the supervision of a licensed physician.

The intent of this release is to grant authority to administer and perform any and all examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the course of the patient's care, be deemed advisable or necessary by any qualified physician. Payment for all charges incurred for medical treatment is guaranteed by the parent/guardian or insurance company providing coverage for the listed youth(s).

Medical/Health Insurance Co. Name _____ Policy/Group No. _____

Address of Insurance Co. _____ City, State, Zip Code _____

If Group Policy, name of Employer _____ Phone No. _____

Insurance issued in the name of _____

Address of insured _____ City, State, Zip _____

Please provide a copy of the front and back of your insurance card.

Child's Full Name _____ **DOB** _____ **Grade (last completed)** _____ **Male Female**

In connection with the provision of medical treatment, be advised of the following regarding the above-named youth: Handicap, limitation, or medical condition _____

Allergies (general or medicated) _____

Previous Operation or Serious Illnesses _____

Any Current Medications: (list) _____

Special Diet: (Name) _____

Has this child been exposed to any contagious disease in the last six months? _____ If so, what? _____

Date of Last Tetanus Shot _____/_____/_____

Child's Full Name _____ **DOB** _____ **Grade (last completed)** _____ **Male Female**

In connection with the provision of medical treatment, be advised of the following regarding the above-named youth: Handicap, limitation, or medical condition _____

Allergies (general or medicated) _____

Previous Operation or Serious Illnesses _____

Any Current Medications: (list) _____

Special Diet: (Name) _____

Has this child been exposed to any contagious disease in the last six months? _____ If so, what? _____

Date of Last Tetanus Shot _____/_____/_____

Child's Full Name _____ **DOB** _____ **Grade (last completed)** _____ **Male Female**

In connection with the provision of medical treatment, be advised of the following regarding the above-named youth: Handicap, limitation, or medical condition _____

Allergies (general or medicated) _____

Previous Operation or Serious Illnesses _____

Any Current Medications: (list) _____

Special Diet: (Name) _____

Has this child been exposed to any contagious disease in the last six months? _____ If so, what? _____

Date of Last Tetanus Shot _____/_____/_____

**(If more room is needed for other children,
please attach another sheet of paper)**

Signature of Parent(s) Date _____, 2010

Sworn to and subscribed before me this _____ day of _____, 2010

NOTARY PUBLIC _____ **My commission expires:**
State of Alabama, County of Jefferson

Print Name of Notary Public