2019-2020 EAU GALLIE FIRST BAPTIST CHURCH
MEDICAL RELEASE/PERMISSION SLIP (Fill out both sides)

I/We the undersigned parent(s) or legal guardian(s) of the minor listed below:

First: _____ MI: _____ Last: _____

Address: _____

City: _____ ST: _____ Zip: _____

Home Phone: (_____) _____ Student Cell: (_____) _____

Student E-Mail: _____

Age: _____ D.O.B. (day/month/year): ____/____/____ Grade: _____

School: _____

parent /guardian name to contact in an Emergency:

Name _____ Relationship to Student _____

Home Phone: (_____) _____ Mobile Phone:(_____) _____

Work Phone: (_____) _____ Which is best to contact you? H M W

Person(s) to be reached if parent/guardian cannot be contacted:

Name: _____ Phone: (_____) _____ Relationship: _____

Name: _____ Phone: (_____) _____ Relationship: _____

RELEASE OF LIABILITY

I/We, the undersigned parent(s)/legal guardian(s) of the above minor (s), do hereby release and agree to hold harmless EG First Baptist Church and any related member, employee, sponsor or agent from any liability, injury, damages, loss, accidents, delay, or irregularity related to the listed minor's planned participation in ***Eau Gallie First Baptist Church, (Event_____)****This release covers all rights and actions of every kind, nature, and description, which the minor and his/her parent(s)/legal guardian(s) ever had, now has, or but for the release, may have. I give permission to Eau Gallie First Baptist student and children ministry staff person and volunteers (who are all background checked) to drive my child to student ministry events and Life group activities.*

_____ _____ _____

(signature of parent/guardian) (date) (relationship)

AUTHORIZATION FOR EMERGENCY MEDICAL CARE TO A MINOR

I/We the undersigned parent(s) or legal guardian(s) of the minor listed below:

First: _____ MI: _____ Last: _____

do hereby authorize any necessary examination, anesthetic, dental or surgical diagnosis or treatment by a duly licensed physician or dentist, or at a hospital licensed by the State of Florida in case of emergency where the parents or guardians cannot be reached.

_____ _____ _____

(signature of parent/guardian) (date) (relationship)

Please list any allergies: _____

Please list any medications and information regarding those prescriptions: _____

_____

_____

Does your child have diabetes, hypoglycemia, medical, or behavioral disorders of which the adult youth leader should be aware?_____

Does your child have a history of seizures? Yes _____ No _____

Is your child a proficient swimmer? Yes _____ No _____

Please provide any other helpful health information: _____

_____

_____

Medical Insurance Company: _____ Policy #: _____

Contact Person: _____ Phone Number: (_____) _____

OVER-THE-COUNTER MEDICATION RELEASE

By indicating "Y" beside the listed over-the-counter medications and signing below, I authorize a representative of Eau Gallie First Baptist Church and/or medical professionals to administer said medication in accordance with label instructions if requested by my child.

Advil _____ Tylenol _____ Benadryl _____

Tums _____ Pepto Bismol _____ Imodium AD _____

Dramamine _____ Prescription Meds sent w/Student _____