

**Medical Release / Permission Form
Shadow Hills Baptist Church**

<i>Date Submitted:</i>		<i>Group Name:</i>			
<i>Activity:</i>			<i>Sponsor:</i> Shadow Hills Baptist Church		
<i>Date of Activity:</i>		<i>Destination:</i>			
<i>Full Name of Child, Youth, Student:</i>					
<i>Sex:</i> <i>Male Female</i>		<i>Birthday:</i>		<i>Age:</i>	<i>Grade:</i>
<i>Parent/Guardian Name:</i>					
<i>Home Address:</i>		<i>City:</i>		<i>State:</i>	<i>Zip:</i>
<i>Emergency Phone</i> ()		<i>Business:</i> ()		<i>Cell:</i> ()	
MEDICAL INFORMATION (MUST BE COMPLETED)					
<i>Policy #:</i>				<i>Policy Holder:</i>	
<i>Insurance Coverage:</i>			<i>Phone:</i> ()		<i>Physician:</i>
<i>Address:</i>					
<i>List Any Medical Problems:</i>					
<i>Allergies:</i>			<i>Medications:</i>		
<i>Last Tetanus Shot:</i>			<i>Dentist:</i>		
<i>Physical Limitations:</i>					
<i>Other Comments:</i>					
PLEASE SEE REVERSE SIDE OF FORM FOR SIGNATURE/ AUTHORIZATION.					

I understand that Shadow Hills Baptist Church ministry) carries medical and hospitalization insurance coverage which, consistent with the exclusions, limitations and terms thereof may provide benefits over and above any personal medical and hospitalization coverage available to my family. I understand that any personal medical and hospitalization insurance available to my family will provide primary coverage and the ministry's medical and hospitalization coverage (subject to the exclusions, limitations and provisions in the ministry's policy), may provide secondary of excess coverage. I agree to apply first for benefits from the personal hospitalization and medical coverage available to my family, if any, before applying for benefits that may be available from the ministry's medical and hospitalization coverage.

I further understand that, in the event that my child requires medical or dental treatment while engaged in the Activity, reasonable efforts will be made to contact me; however, if I cannot be reached, I hereby consent and give permission to the ministry's sponsor or any adult counselor acting on behalf of the ministry with respect to the Activity, as agent for me, to consent to any X-ray examination; injections; anesthesia; medical, dental or surgical diagnosis and treatment; and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the State where the services are rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed all of my child medical allergies, medications being taken, medical problems and the pertinent information. My child has permission to participate in all prescribed activities except as noted by me.

Signature_____ Date_____