MEDICAL AND SURGICAL WAIVER/ AUTHORIZATION FOR TREATMENT/ RELEASE OF ALL CLAIMS

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth (mm/dd/yyyy): _____ Gender: Male Female

In the event there arises an emergency, necessitating medical and/or surgical attention, I/we hereby consent and give permission for an attending physician or hospital to administer and perform the medical care, treatment, and/or surgery deemed necessary by said attending physician of hospital and for said attending physician or hospital to make said decisions regarding medical care, treatment and/or surgery upon the above named which they, in their sole discretion, deem to be necessary and proper under the circumstances.

I/we, do hereby, for myself or my minor child, release, acquit, discharge and forever hold harmless Dalraida Baptist Church, its officers, agents, and representatives, sponsors and group members, from any and all claims, demands, causes of action, damages and liabilities for personal injury, sickness and death, as well as property damages and expenses, arising out of any accident, sickness, or illness and the treatment thereof, during said function or trip. Further, should it be necessary for the above to return home due to medical reasons, or otherwise, I/we hereby expressly assume responsibility for all transportation costs.

IN THE EVENT OF EMERGENCY, _____, (name & relation) WILL BE NOTIFIED, IF POSSIBLE, BEFORE MEDICAL ATTENTION IS ADMINISTERED.

Emergency Contact Phone: ( ) _____ or ( ) _____

I/we understand that this MEDICAL AND SURGICAL WAIVER/ AUTHORIZATION FOR THE TREATMENT/ RELEASE OF ALL CLAIMS covers the period from January 4, 2024 – January 4, 2025.

Signature _____ Date_____
(For minors 18 years & under, parents/guardians must sign)

**ALL AGES ARE REQUIRED TO HAVE THIS FORM SIGNED IN THE PRESENCE OF A NOTARY PUBLIC **

Signature _____ Date_____
(To be signed in the presence of Notary Public)

_____, personally appeared before me and known by me, and in my presence executed the within and forgoing Medical and Surgical Waiver/Authorization for Treatment/ Release of All Claims form.

Witness my hand and official seal this _____ day of _____, year _____.

Notary Public _____
My commission expires: _____ *continues on back*>>

Medical Profile

(Note: All questions must be answered.)

Home Address:_____

Doctor: _____ Office Phone: ( ) _____

Medication Allergies or other Allergies:_____

_____

Any medical problem(s) that might need attention: _____

_____

_____

Medications taken: _____

_____

_____

Date of last Tetanus shot: _____

Do you give permission for Tylenol or a similar substance to be provided for minor ailments? Yes No

Health Insurance Company:_____

Policy Number: _____

For people under 18 years old:

Full Name of Father: _____

Date of Birth (mm/dd/yyyy): _____

Full Name of Mother: _____

Date of Birth (mm/dd/yyyy): _____

Please attach a copy of insurance card (front and back).