Keltys First Baptist Church Medical Release Form

2402 N. John Redditt Dr. Lufkin, Texas 75904
Effective dates: September 1st, 2024 through August 31st, 2025 (unless revoked by notarized written notice)

STUDENT INFO: Please print in ink

_____

LAST FIRST MIDDLE

Age _____ Birthday _____ Male □ Female □

Year in school _____ School Attending _____

Home Address _____ City_____ State ___ Zip _____

Phone / cell _____

PARENT(s) INFO:

Father's name: _____ Mother's name: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Email: _____ Email: _____

Emergency contact:

Name and Relationship to student: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

We expect each student to conform to these rules of conduct:

- No possession or use of alcohol, drugs, or tobacco
- No students drive to any events unless specific request has been signed by youth pastor AND parent/guardian
- No fighting, weapons, fireworks, lighters, or explosives
- No offensive or immodest clothing
- No boys in girls' sleeping quarters and no girls in boys' sleeping quarters
- Participation with the group is expected
- Respect property
- Respect one another, staff, and adult leaders
- Respect and comply with event schedules

Students who fail to comply with these expectations may be sent home at their parents' expense.
I, the student, have read the rules of conduct, the above evaluation of my health, and permission to participate in youth group activities. I agree to abide by the stated personal limitations and code of conduct.

Student's Name _____Signature: _____ Date: _____

HEALTH / DENTAL INSURANCE INFORMATION

Health Insurance Company: _____

Policy Number: _____ Group Number: _____

Primary Named Insured on Policy: _____

Address:_____ Phone Number: _____

Dental Insurance Company: _____

Policy Number: _____ Group Number: _____

Address: _____ Phone Number: _____

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be

aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

Check the following areas of concern for this student. If necessary, add another page with details:

1. For your child's safety and our knowledge, is your student a __ good swimmer __ fair swimmer __ non-swimmer
2. Does your child have allergies to __ pollens __ medications __ food __ insect bites __ other _____
3. Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:
__ asthma __ epilepsy / seizure disorder __ heart trouble __ diabetes __ frequently upset stomach __ physical handicap
4. Date of last tetanus shot: _____
5. Does your child wear: __ glasses __ contact lenses __ hearing aids __ other: _____
6. Please list and explain any major illnesses the child experienced during the last year: _____

_____

7. Please list any additional information that would be helpful in understanding your child's medical needs:

_____

8. Should your child's activities be restricted for any reason? Please explain:_____

_____

Activities may include, **but are not limited to**: cookouts, boating, water skiing, swimming, basketball, roller-skating, rollerblading, games in the park, soccer, basketball, ice skating, volleyball, all activities associated Summer Camp, downhill skiing, snowboarding, hiking, concerts, Bible studies, miniature golf, all activities associated with Mission Trips.
Note: If you desire to limit your child's participation in any event, please submit your wishes in writing to the church youth pastor prior to that event.

AUTHORIZATION FOR MEDICAL TREATMENT

As a parent or legal guardian of _____ ("Minor"), each of the undersigned gives his or her authorization and consent for Keltys First Baptist Church and the KFBC's adult employees, agents, and volunteers (collectively with KFBC, the "KFBC Parties") to seek, authorize, and consent to such medical or dental care for Minor ("Treatment") as any one or more of them may deem necessary or appropriate. Such Treatment (1) shall be provided upon the advice of and supervision by a physician, surgeon, dentist, or other medical practitioner licensed to practice under the laws of the state or jurisdiction in which such Treatment is sought, and (2) may include, without limitation, X-ray examination; anesthetic; medical, dental, or surgical diagnosis or treatment; and hospital care. Every effort will be made to contact one of the signers of this authorization before treatment is authorized whenever possible. This Authorization for Medical Treatment may be a photocopy hereof and shall be as valid as an original copy. Each of the undersigned acknowledges and agrees that the KFBC Parties shall not be legally or financially liable for any bill or expense incurred in, or any cause of action or claim arising from, the provision of any Treatment or the failure to provide or seek any Treatment. In consideration on Minor's participation in one or more events sponsored by KFBC, each of the undersigned hereby agrees to indemnify, defend, and hold harmless Keltys First Baptist Church from and against any and all losses, damages, liabilities, or expenses (including, without limitation, reasonable attorneys' fees and other costs of defense) in connection with any and all actions, suits, claims, or demands that may be brought or instituted against any KFBC Party and arise out of or result from the provision of any Treatment or the failure to provide or seek any Treatment. This paragraph shall survive any termination or expiration of the Authorization for Medical Treatment for any reason. By my signature below I acknowledge this consent is in affect from September 1st, 2024 through August 31st, 2025.

Name: * _____ Signature: _____ Date: _____

Name: * _____ Signature: _____ Date: _____

**Note: Each person who has legal custody of Minor should sign this Authorization for Medical Treatment, and only a person who signs will be considered a legal custodian of Minor.*

(This form must be Signed and Dated only in the presence of a notary)

STATE OF Texas

COUNTY OF Angelina

Subscribed and sworn to before me on _____ day of _____, 20____.

_____ _____

Notary Public My Commission Expires