

**2012 WEST SIDE BAPTIST MEDICAL RELEASE FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number:(\_\_\_\_) \_\_\_\_\_ Social Security No: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

In case of emergency,

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy/Group No.: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber No: \_\_\_\_\_

**Past Medical History:**

Date of last tetanus immunization: \_\_\_\_\_

Immunizations: \_\_\_\_\_ Polio Booster \_\_\_\_\_ Measles \_\_\_\_\_ Mumps

Please check past medical information, giving appropriate information if needed about all marked areas:

Asthma \_\_\_\_\_ Dizziness \_\_\_\_\_ Kidney Trouble \_\_\_\_\_

Bronchitis \_\_\_\_\_ Hay Fever \_\_\_\_\_ Sinusitis \_\_\_\_\_

Diabetes \_\_\_\_\_ Heart Trouble \_\_\_\_\_ Stomach Lining \_\_\_\_\_

Any other conditions: \_\_\_\_\_

**OVER:**

**Allergies: (List Type)**

Drug Names(s): \_\_\_\_\_

Food(s): \_\_\_\_\_

Insect stings/bites: \_\_\_\_\_

Poison sumac, oak, ivy: \_\_\_\_\_

**Other Information:**

Previous operations: \_\_\_\_\_

Long term medications: \_\_\_\_\_

Special Diet: \_\_\_\_\_

Other Medical Information: \_\_\_\_\_

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**Permission for Treatment:**

**My permission is granted for the Minister to Students at West Side Baptist Church, or any other adult leadership personnel in charge to obtain necessary medical attention in case of sickness or injury to my child.**

**I, the undersigned, do hereby verify that the above information is correct and I do hereby release and forever discharge all sponsors of West Side Baptist Church from any and all claims, demands, actions, or cause of action, past, present, or future arising out of any damage or injury while employed by or participating in all youth activities and trips.**

**Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, State of Virginia, City of Harrisonburg.**

**Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Relationship to Student:** \_\_\_\_\_