All beKids Ministry Events Medical Release & Permission Form



Name:			Age: _	Birth	ıday:
LAST	FIRST	MIDDLE			
Grade in school:	☐Male☐ Female	T-Shirt	Parent Email:		
Address:		City:		State:	Zip:
Medical insurance company:		Policy #:			
Mother's name:		Phone: Home		Cell	
Father's name:		Phone: Home		Cell	
mergency contact:		Phone: Home		Cell	
Physician:			Office phone: _		
Dentist:		Office phone:			
Medical History					
2. Does your child have all	and our knowledge, fair swimmer	is your child a: ∕ ∏non	swimmer		ails: □other
List allergies:					
3. Does your child suffer fr ☐ asthma ☐ frequently upset List Medications if Applical	epilepsy / s	eizure disorder ⁄sical handicap	∏heart	trouble	ne following: diabetes
4. Date of last tetanus sho	t:				
5. Does your child wear:	glasses	Сог	ntact lenses		
6. Please list and explain a	any major illnesses t	the child experie	nced during the la	st year:	

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Should this child's activities be restricted for any reason? Please explain:	
These events will include but are not limited to camp, summer activit transportation.	ties, and any other event that requires
(We) do hereby give our approval for	to attend all the
beKids Ministry Events for January 2020 to January 2021. (child's	name)
This consent form gives permission to seek whatever medical attention is and its staff of any liability against personal losses of named child.	deemed necessary, and releases the Church
I/We the undersigned have legal custody of the child named above, a minerattend events being organized by the Church. I/We understand that there athletic event, and I/we hereby release the Church, its pastors, employees all liability for any injury, loss, or damage to person or property that may organized the event that he/she is injured and requires the attention of medical treatment as deemed necessary by a licensed physician. In the every hospital personnel designated by the Church, I/we agree to hold such produced providers for damages arising from the giving of such consent. I/We responsible for the cost of any medical care should the cost of that medical insurance provider. Further, I/we affirm that the health insurance information will, to the best of my/our knowledge, still be in force for the child named a shome at my/our own expense should they become ill or if deemed necess	are inherent risks involved in any ministry or s, agents, and volunteer workers from any and ccur during the course of my/our child's of a doctor, I/we consent to any reasonable vent treatment is required from a physician and terson free and harmless of any claims, We also acknowledge that we will be ultimately all care not be reimbursed by the health on provided above is accurate at this date and bove. I/we also agree to bring my/our child
	Date

Signature of Parent/Guardian

