FIRST BAPTIST CHURCH VALLEY MILLS

302 AVE . C, VALLEY MILLS, TX 76689 254-932-6273

CONSENT & RELEASE FROM LIABILITY & MEDICAL CONSENT FORM

(DISCIPLE NOW 2021)

_______________________________ has my permission to participate in all activities of First Baptist Church Valley Mills and to be transported by church bus or private car when necessary. I understand that all events will have adult supervision. In consideration of the benefits to be derived from these activities, I hereby voluntarily waive any claim against First Baptist Church Valley Mills, its employees, volunteers, or sponsors. I also hereby voluntarily waive any claim against the owner/ driver of the car or bus furnishing transportation to any event. I further agree to direct my son/daughter to conform to the fullest with the directions and instructions of the sponsors in charge.

In the event that my child becomes ill or sustains an injury while on an authorized and chaperoned outing from First Baptist Church Valley Mills, I, the undersigned, give my permission to those in charge to take whatever steps necessary to stop any bleeding and to administer first aid.

I also consent to an x-ray examination, anesthetic, medical(or dental) or surgical diagnosis and treatment and hospital care, and the administration of drugs or medicine to be rendered to my child under the general or specialized supervisor and upon the advice of a duly licensed physician or surgeon.

This consent and release is in effect from the date signed. I understand that a copy of this form is as valid as the original.

Parent/Guardian signature: ____________________________________ Date: ____________

Street Address: _______________________________________ City:___________________

State: ___________ Zip Code: ___________ Email:__________________________________

Phone: _______________________ Work Phone: __________________________

Individual Health Information

Name: __________________________________ Date of Birth ____/____/______

Weight: __________ Height:___________

Describe any health problems: ____

____

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Any Medications: Yes ___ No___ If yes, names of drugs and dosages:____________________

____

Allergic to any medications: Yes___ No___ If yes, please list:____________________________

____

Physician's name:________________________ Office Phone:___________________________

Address:____

Name of Medical Insurance Company:____

Phone:_______________________________ Policy Number: _________________________

Group Number: _______________________________