



**MEDICAL RELEASE FORM**

1. Pursuant to the provision of the civil code of the State of Florida, I the undersigned, \_\_\_\_\_, do hereby authorize the adult supervisors of the student ministries department of the Olive Baptist Church of Pensacola, Florida, to consent to any diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practice Act, or by a dentist licensed under the provisions of the Dental Practice Act. It is understood that this authorization is given in advance of any specific care being required, be it given to provide authority to give care which physician may, in the exercise of his/her best judgment, deem advisable.
2. I hereby authorize that the Olive Baptist Church leaders that have training in/as First Aid Treatment or Emergency Medical Technicians or Registered or Licensed Nurses may perform care upon me in accordance with the level of training they have received as deemed necessary by them.
3. I hereby release Olive Baptist Church of Pensacola, Florida and its' leaders (both paid and volunteer staff) from liability in case of accident.
4. These authorizations shall remain effective until revoked in writing and delivered to said agent.

STATE OF FLORIDA  
COUNTY OF ESCAMBIA

Personally appeared before me, \_\_\_\_\_, who acknowledged that he/she executed the within instrument for the purposes therein contained. Witness my hand this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

**(AFFIX SEAL BELOW)**

\_\_\_\_\_  
(Notary Signature)  
Commission Expires: \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Medical Information

### Personal Information:

Name \_\_\_\_\_ Soc. Sec. Num. \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_ D.O.B. \_\_\_\_\_

### Medical Problems:

1. List Date of Immunization where apply: DPT \_\_\_\_\_ MMR \_\_\_\_\_ Tetanus Only \_\_\_\_\_
2. Check if Student Has Had:  
Chicken Pox \_\_\_\_\_ Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Other \_\_\_\_\_

3. Do you have any medical problems listed below (circle all that apply):  
Allergies \_\_\_\_\_ Asthma \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Condition \_\_\_\_\_  
Hypoglycemia \_\_\_\_\_ Epilepsy or other nervous disorders \_\_\_\_\_ Other \_\_\_\_\_

Please Explain: \_\_\_\_\_

\_\_\_\_\_

4. Are you allergic to any food, insects, or medicine? \_\_\_\_\_

\_\_\_\_\_

5. Do you have any current medications: \_\_\_\_\_

\_\_\_\_\_

### Emergency Contact Information:

#1 Name \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_  
Work Phone (\_\_\_\_\_) \_\_\_\_\_ Pager/Cell Phone (\_\_\_\_\_) \_\_\_\_\_  
Employer \_\_\_\_\_

#2 Name \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_  
Work Phone (\_\_\_\_\_) \_\_\_\_\_ Pager/Cell Phone (\_\_\_\_\_) \_\_\_\_\_  
Employer \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_ ID# \_\_\_\_\_  
Family Doctor \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_