



olive baptist church high school ministry

MEDICAL RELEASE FORM

1. Pursuant to the provision of the civil code of the State of Florida, I the undersigned, legal guardian of _____, a minor, do hereby authorize as agents, 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 my child in accordance with the level of training they have received as deemed necessary by them.
3. I hereby authorize any hospital, which has provided treatment to the above named minor to surrender physical custody of such minor to my above named agent upon completion of treatment. This authorization is given pursuant to the Health and Safety Code.
4. I hereby release Olive Baptist Church of Pensacola, Florida and its' leaders (both paid and volunteer staff) from liability in case of accident.
5. I hereby request the above named agent to carry out discipline deemed necessary for my child. I also agree to pay the expenses of my child's trip home because of disciplinary action.
6. 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: _____

Adult Signature _____ **Date** _____

Circle one: PARENT LEGAL GUARDIAN PERSON HAVING LEGAL CUSTODY

Medical Information

Personal Information:

Student Name _____ Soc. Sec. Num. _____
Address _____ City _____
State _____ Zip _____ County _____ D.O.B. _____

Medical Problems:

1. List Date of Immunization: DPT _____ MMR _____ Tetanus Only _____ Polio _____

2. Check if Student Has Had:

Chicken Pox _____ Measles _____ Mumps _____ Whooping Cough _____
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: _____

Parent/Guardian Emergency Contact Information:

Parent or Guardian Name _____ Home Phone (_____) _____
Work Phone (_____) _____ Pager/Cell Phone (_____) _____
Employer _____

Parent or Guardian Name _____ Home Phone (_____) _____
Work Phone (_____) _____ Pager/Cell Phone (_____) _____
Employer _____

Medical Insurance Carrier _____ ID# _____
Family Doctor _____ Phone (_____) _____

Secondary Emergency Contact Information:

Name _____ Home Phone (_____) _____

Relationship to Student _____