Medical Release Form

First Baptist Church
401 W. Union
Marion, IL 62959
618-997-9386

Name: _____ Birthdate: _____ Age: _____
Address: _____
Home Phone Number: _____
Parent/Guardian: _____

In Case of an Emergency, please notify:
Name: _____ Relationship: _____ Phone: _____

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Health History: Allergies, Diseases and Immunizations
Check all that apply, giving approximate dates where appropriate:

Frequent Ear Infections	_____	Hay Fever	_____	Chicken Pox	_____
Heart Defect/Disease	_____	Measles	_____	Convulsions	_____
Insect Stings	_____	German Measles	_____	Diabetes	_____
Penicillin	_____	Mumps	_____	Bleeding/Clotting	_____
Asthma	_____	Tetanus	_____	Disorders	_____

Allergies to other Medicine, or other pertinent medical information (list below):
_____
_____

Name of Family Physician: _____ Phone: _____
Name of Dentist/Orthodontist: _____

Insurance Coverage: _____
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This information is correct and accurate so far as I know, and the person herein described has permission to engage in all activities, except as noted:

I hereby give permission to the physician selected by the camp director or a sponsor of Marion First Baptist Church to order X-rays, routine tests and treatments for the health of my child, and, in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director or a sponsor of Marion First Baptist Church to transport, hospitalize, secure proper treatment for, and order injections and/or anesthesia and/or surgery for my child as named above. I further agree to pay reasonable cost for medical treatment rendered.

Parent/Guardian Signature _____ Date: _____
Witness: _____ Date: _____