FIRST BAPTIST CHURCH OF ORANGE PARK
1140 Kingsley Avenue
Orange Park, FL 32073
(904) 264-2351

MEDICAL/TRAVEL RELEASE FORM

PARTICIPANT'S NAME _____ AGE _____ DATE OF BIRTH _____

PARENT/GUARDIAN _____ ADDRESS _____

CITY/STATE/ZIP _____

HOME PHONE _____ WORK PHONE _____ OTHER EMERGENCY PHONE (cell, pager, etc.) _____

FAMILY DOCTOR _____ ADDRESS _____ PHONE _____

This is to release and hold harmless First Baptist Church Orange Park and its ministers and staff from any and all responsibility or liability arising out of the participant's involvement in all preschool/children/student ministry activities. In the absence of one of the participant's parents or guardians, First Baptist Church Orange Park is authorized to administer first aid or to obtain consent for any emergency first aid or medical care by any physician, hospital, or attendant which may be needed by the participant as a result of involvement in the activity. I agree to abide and be bound by such decisions or consents as made by First Baptist Church Orange Park and do assume full financial responsibility for and agree to pay all expenses of such care. I further understand that by present Florida Law: if the participant is riding in a church vehicle which is involved in an accident, he/she will be primarily covered by bodily injury under our family automobile policy.

I further agree that if my son or daughter creates a disciplinary problem, I will be responsible for all costs related to his/her early return.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

EMERGENCY CONTACT PERSON AND PHONE NUMBER _____ SECONDARY EMERGENCY CONTACT PERSON AND PHONE NUMBER _____

STATE OF FLORIDA, COUNTY OF _____

The foregoing instrument was acknowledged before me the _____ day of _____

By _____
(Name of parent/guardian)

Personally known _____ or Produced I.D. _____ (Type of I.D. _____)

Notary Signature _____ Print/Type/Stamp Name of Notary _____
Notary Public State of Florida

(OVER)

MINOR CHILDREN MEDICAL TREATMENT CONSENT FORM

NAME _____ DATE OF BIRTH _____

ADDRESS _____ HOME PHONE _____

CITY/STATE/ZIP _____

MEDICAL HISTORY _____

DRUG ALLERGIES _____ LAST TETANUS SHOT _____

CURRENT MEDICATIONS _____

FATHER'S NAME _____ EMPLOYER _____

EMPLOYER'S MAILING ADDRESS _____

CITY/STATE/ZIP _____

EMP. PHONE _____

MOTHER'S NAME _____ EMPLOYER _____

EMPLOYER'S MAILING ADDRESS _____

CITY/STATE/ZIP _____

EMP. PHONE _____

PRIMARY INSURANCE
COMPANY NAME _____

EMPLOYER, GROUP, OR INDIVIDUAL _____ IN WHICH PARENT'S NAME _____

GROUP # _____ CONTRACT # (POLICY ID #) _____

MAILING ADDRESS
FOR CLAIMS _____ CITY/STATE/ZIP _____

SECONDARY INSURANCE
COMPANY NAME _____

EMPLOYER, GROUP, OR INDIVIDUAL _____ IN WHICH PARENT'S NAME _____

GROUP # _____ CONTRACT # (POLICY ID #) _____

MAILING ADDRESS
FOR CLAIMS _____ CITY/STATE/ZIP _____