INFORMATION, MEDICAL RELEASE AND PERMISSION FORM
Godwin Heights Baptist Church, Inc.

NAME: _____ **PHONE:** _____

ADDRESS: _____

PARENTS: _____**DOB:** _____

In case of an emergency notify: _____

Emergency Contact #: _____

I, the undersigned, do hereby certify that I am the parent or legal guardian of _____, and that she/he has joined Godwin Heights Baptist Church group with my full permission, knowledge and consent. I understand there will be trips, retreats, camps, and general projects for the Youth and Children's programs. If my child demonstrates inappropriate behavior, I accept responsibility for his/her transportation to return home per telephone call from the Minister of Youth/Directors in charge.

I do hereby release and forever discharge Godwin Heights Baptist Church, the Minister of Youth and/or Directors of this program or other leaders or members of this organization from any and all claims, demands, damages, injuries, costs, suits or causes of action, past, present, or future arising out of any damage or injury to my son/daughter while participating in the Youth/Children's programs, activities, events or trips except to the extent that said liabilities covered by a policy of liability insurance purchased by Godwin Heights Baptist Church.

In the event that our son/daughter does receive an injury or the nature which would warrant medical treatment, I hereby authorize the said leader or any other leader of the above said Youth or Children's program to take whatever emergency medical precautions or steps necessary for the safety and welfare of our son/daughter to include granting permission to qualified doctors and other medical personnel to do anything which they deem necessary for him/her. This instrument shall constitute authority to said leaders to sign any papers required contingent upon our child receiving emergency medical treatment.

ALLERGIES: Medicine or Other: _____

Please list any medical conditions we should be aware of: _____
_____

Daily Medications: _____

Does he/she have any handicap that would hinder him/her from entering into any activities?
If yes, what: _____

On trips, will your child have any medication in his/her possessions?
If yes, what and required dosage: _____

Family Physician: _____ **Phone #:** _____

Insurance Information:
Insurance Co.: _____ Policy #: _____
Subscriber Name: _____ Place of Employment: _____

Signed: _____ **Date:** _____
(parent/guardian)