

M e d i c a l R e l e a s e F o r m

Colonial Baptist Church Children's Ministries

EVENT INFORMATION

Name of event: _____

Location: _____

Date: _____

REGISTRATION INFORMATION

Child's Full Name: _____

Full Address: _____

Birthdate: _____

Phone Number: _____

Parent(s) or Guardian(s): _____

Emergency Contact: _____

(Name and Phone Number)

MEDICAL RELEASE

I, as legal guardian, hereby grant Colonial Baptist Church, it's agents, or any licensed medical personnel authority to make decisions on my behalf regarding emergency medical treatment for the above named child during the above mentioned event(s).

Signature of Guardian: _____

Date: _____

Medical Insurance Company, Policy Number and Group Number: _____
