Valid for events and activities for 2019

CYPRESS KIDS

Chaperone Medical Release Form

Participant Name_____ Age_____Date of Birth_____

Address_____

City_____ State_____ Zip Code_____

Emergency Contact Person

Name_____

Address_____

City_____ State_____ Zip Code_____

Phone (cell)_____(home)_____(work)_____

Alternate Contact Person

Name_____

Address_____

City_____ State_____ Zip Code_____

Phone (cell)_____(home)_____(work)_____

Insurance

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while you are at this activity.

Do you have health insurance? Yes_____ No_____

Name of Insurance Company_____

Policy Number _____ Group Number_____

In whose name is the insurance_____

Family Doctor

Name_____ Phone _____

City_____ State_____ Zip Code_____

If you should require medical attention for injuries received or illness contracted prior to activity, please provide the necessary information to secure proper medical care while participating in this event.

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Health History

Pre-existing or present medical conditions _____

_____

Name and dosage of any medications that must be taken _____

_____

_____

Any Allergies_____

Hay Fever_____ Heart Condition_____ Diabetes_____ Insect Stings_____

Epilepsy/Nervous Disorders_____ Asthma_____ Frequent Stomach Upsets_____

Physical Handicap_____ Any major illness during the past year_____

If any of the above are checked, please give details (include normal treatment)

_____

_____

Date of last tetanus shot_____ Contact Lenses_____

Any Swimming Restrictions (yes)_____ (no)_____

If yes, what _____

Any Activity Restrictions (yes)_____ (no)_____

If yes, what _____

Permission for Medical Treatment, Release and Indemnity

Permission is granted for the camp or event director, church official, any event staffer, or adult present or in charge of First Aid, to obtain necessary medical attention in case of illness or injury to me. I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. I hereby give permission to the physician or dentist selected by the activity leader to hospitalize, to secure medical treatment and/or to order an injection, anesthesia, or surgery as deemed necessary.

I understand that my insurance coverage will be used as primary coverage in the event medical intervention is needed. Coverage by Cypress Baptist Church through its accident policy will be used as a backup for what my insurance does not cover.

I, the undersigned, do hereby verify that the above information is correct. I do hereby release and forever discharge Cypress Baptist Church, camp or event sponsors, the state convention, and their employees from any and all claims, demands, actions or causes of actions, past, present, and future arising out of any damage or injury while employed by or participating in a camp or event.

I agree that Cypress Baptist Church may ____ may not ____take and use photographs of myself with or without my name and for any lawful purpose, including for such purposes as publicity, illustration, advertising, and web content.

Participant's Signature_____ Date_____