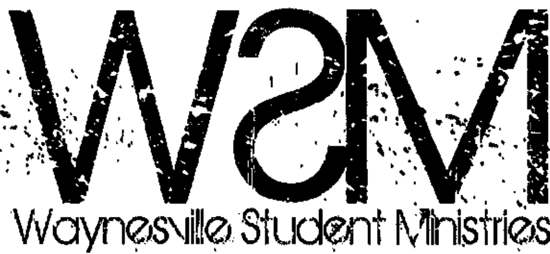

1009 Lytle Road
Waynesville, OH 45068
513.897.1009
www.fbcwaynesville.net

Medical Release and Indemnity Agreement Form

Student Information:

Student's Name:______________________________ Date of Birth:________________

Home Address:______________________________ Phone Number:________________

City, State, Zip:______________________________

Parental/Guardian Information:

Parent/Guardian Name:______________________________ Phone Number:________________

Home Address:______________________________

City, State, Zip:______________________________

Agreement Statement:

I, the parent or guardian named above, do hereby authorize to consent for all medical and/or surgical treatment and/or other medical procedures for the above named student, which may be required in my absence. If circumstances permit, I would like to have our doctor consulter in connection with such treatment.

We fully understand that Waynesville First Baptist church carries no insurance covering injuries sustained by players participating any activity. We also fully understand the risks involving personal injury which may arise during the course of the activity, and voluntarily assume said risks and further agree on our own behalf of the student named above to release, indemnify and hold harmless Waynesville First Baptist Church, members of the Board, agents, and assignees from any all liability, claims, actions, demands and judgments arising out of any and all injuries to the student named above sustained while participating in activity at Waynesville First Baptist Church. It is further understood and agreed that Waynesville First Baptist Church, its Board, agents, and assignees do herewith disclaim any and all injuries that may occur.

Signatures:

______________________________ ________________

Parent/Guardian (Circle One) Date

______________________________ ________________

Parent/Guardian (Circle One) Date

Additional Medical Information

Family Physician Information:

Name:______________________________ Phone Number:______________

Address:______________________________

____

Insurance Information:

Insurance Carrier:______________________________ Policy Number:______________

Member Services Phone Number:______________

Medical Information *(Please print and be thorough)**:***

Chronic or existing Medical Conditions
(e.g., Asthma, Seizures, Diabetes)

____

____

Known Allergies:

____

____

Current Daily Medications:

____

____

Recent Shots and Vaccinations:

Tetanus/Date:______________________ Other/Date:______________________