



# Summit Baptist Church Student Medical Release 2015-2016

\_\_\_\_\_ is to receive any necessary medical treatment in my absence. I understand that in the event that my youth requires medical attention, a representative of Summit Baptist Church will contact me. However, in the event that I cannot be reached, I give the authority for medical treatment decisions for my youth to Summit Baptist Church representative in possession of this document and if necessary obtain the services of a licensed physician and/or hospital emergency room. Below, I have noted any special medical problems, allergies, or other concerns about my youth's health.

Signed \_\_\_\_\_ Date Signed \_\_\_\_\_  
MOTHER / FATHER / LEGAL GUARDIAN

Mother Phone #: Day: \_\_\_\_\_ Night: \_\_\_\_\_ Cell: \_\_\_\_\_

Father Phone #: Day: \_\_\_\_\_ Night: \_\_\_\_\_ Cell: \_\_\_\_\_

### Another Person To Be Contacted In Case Of Emergency

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Phone #: Day: \_\_\_\_\_ Night: \_\_\_\_\_ Cell: \_\_\_\_\_

### Insurance Policy Holder Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone #: \_\_\_\_\_

Medical Problems, Allergies, etc... \_\_\_\_\_

### NOTARY PUBLIC

On this date the person(s) who are signed above personally appeared before me, being personally known by me, and in my presence executed this authorization and release form. Witness my hand and official seal this date \_\_\_\_\_ / \_\_\_\_\_ / 20\_\_\_\_.

\_\_\_\_\_ Notary Public My commission expires \_\_\_\_\_ / \_\_\_\_\_



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