

**Woodland Baptist Church**  
**Medical Release Form for 2009**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

BIRTHDATE: \_\_\_\_\_

HOME PHONE NUMBER: \_\_\_\_\_

CELL PHONE NUMBER: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_

PARENT'S CELL NUMBER: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

INSURANCE POLICY NUMBER: \_\_\_\_\_

ANY ALLERGIES: \_\_\_\_\_

MEDICATIONS TAKEN REGULARLY: \_\_\_\_\_

\_\_\_\_\_

EMERGENCY CONTACT & NUMBER: \_\_\_\_\_

\_\_\_\_\_

I give permission for \_\_\_\_\_ to be treated by a licensed physician if medical treatment is deemed necessary. In case of surgical emergency, I also give my consent to medical procedures diagnosed and prescribed by the attending physician. By affixing my signature below, I do hereby agree to hold harmless the Woodland Baptist Church and all agents and representatives thereof from all claims of losses, injuries, damages, and/or death that may result in me/my child participating in the missions program of Woodland Baptist Church. I further agree to waive any rights of legal action against the said releasees.

\_\_\_\_\_  
Signature of Parent/Guardian (if under 18)

\_\_\_\_\_  
Date