

# FBC Sumrall Student Ministry

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## Medical Release Form / Permission to Treat (To be completed by parent or legal guardian)

### Student/Participant Information:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Parent/Guardian Information:

Parent/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Secondary Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Insurance Information: \*Attach a copy of your insurance card to this form.

Insurance Co.: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy#: \_\_\_\_\_  
Cardholder: \_\_\_\_\_ Relationship to Cardholder: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
Insurance Co. Phone: \_\_\_\_\_

### Personal Medical Information:

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Allergies and Medical Conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List ALL medication taken on a regular basis and/or any brought with you to Camp. (Prescription meds MUST have a pharmacy label and name of doctor.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all operations/serious injuries and dates within the past five (5) years:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is sponsor authorized to approve medical treatment for student/participant if deemed emergency? \_\_\_\_ Yes \_\_\_\_ No

Medical Release Form / Permission to Treat

Student Name: \_\_\_\_\_

Parent / Guardian Name: \_\_\_\_\_

**Medical Release Form / Permission to Treat**

I, the undersigned, acknowledge and accept the risks of physical injury associated with participation in the event/activity described above. The Health History is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. By signing below, I, the undersigned, give FBC Sumrall, its agents, volunteers, employees, or anyone acting on its behalf, permission to treat the above student.

I understand that it is my (parent/guardian) responsibility to inform the staff if there are any changes in my child's medical condition during this year. I understand that this document is valid through August 31, 2022.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**The following should be completed by the notary witnessing parent/guardian's signature.**

The State of \_\_\_\_\_ the County of \_\_\_\_\_ Before me, a Notary Public, on this day personally appeared \_\_\_\_\_ known to me (or proved to me on the oath of \_\_\_\_\_) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration therein expressed. Given under my hand and the seal of the office this

\_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_.

Notary Public, Signature \_\_\_\_\_

My commission expires the \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_.