THIS PAGE WILL NEED TO BE PRINTED AND SIGNED IN THE PRESENCE OF A NOTARY PUBLIC

PARTICIPANT'S MEDICAL INFORMATION

Full Name of Participant: _____ Participant's S.S.#:_____

Date of Birth: _____Address: _____--------_____City _____State ____ Zip _____

Name of Parent/Guardian: _____ Phone #: _____

Relationship to Participant: _____ Alternate Phone: _____

As parent/legal guardian of _____, I do hereby authorize my consent to any X-ray, examination, anesthetic, medical or surgical diagnosis rendered under general or special supervision of any licensed medical staff member under the provision of the Medicine Practice Act. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required, but is given to provide authority and power to render care which the aforementioned physician, in his or her best judgment, may deem advisable. It is understood that effort shall be made to contact me, the undersigned, prior to rendering treatment to my child, but that any of the above treatments will not be withheld if I cannot be reached. I agree to be responsible for paying any charges that may be incurred by such treatment. I hereby release Central Baptist Church of Martin, Tennessee, its staff, and representatives from any liability for accidents or injury sustained by my child in conjunction with any event.

MEDICAL INSURANCE INFORMATION

Insured Parent/Legal Guardian's Name: _____ S.S.#: _____

Insurance Company: _____ Phone: (_____)_____Group/Policy#: _____

Family Physician: _____Doctor's Phone # (____)_____Last Tetanus/DPT immunization date_____

(*PLEASE DO NOT SIGN BELOW UNLESS YOU ARE IN THE PRESENCE OF A NOTARY*)

Signature of Parent/Legal Guardian_____Date_____

_____

NOTARY SEAL

NOTARY ACKNOWLEDGEMENT

Subscribed and sworn to before me,
a Notary Public in and for
_____ County, Tennessee on this

_____ day of _____, 20____

_____

(Signature of Notary Public)

My Commission expires

_____

(Date)