GRACEWAY BAPTIST CHURCH
MEDICAL AUTHORIZATION AND RELEASE OF LIABILITY

(Please print or type)

NAME ____

ADDRESS ____
P.O. or Street Number   City   State   Zip

AGE ______________________ BIRTH DATE ______________________

GENDER: MALE_____ FEMALE_____ T-SHIRT SIZE: ________________

PARENT OR GUARDIAN ____

IN EMERGENCY, NOTIFY ______________________ PHONE ______________

ADDRESS ____

INSURANCE CO. ______________________ POLICY # ______________

FAMILY PHYSICIAN ______________________ PHONE ______________

Check if you or your child-has had the following; use the back to give any details.

___Seizures
___Chicken Pox
___Scarlet Fever
___Polio (disease)
___Rheumatic Fever
___Heart Disease
___Tuberculosis
___Cystic Fibrosis
___Cerebral Palsy
___Surgery
___Diabetes
___Muscular Dystrophy
___Frequent Earaches
___Frequent Sore Throat
___Asthma
___Frequent headaches
___Kidney Disorder
___Hearing Problems

Last Tetanus Shot ______________ List any past serious injuries ______________

List any current medications ____

List any physical restrictions, allergies, etc. ______________________________

Glasses or Contacts ____

IMPORTANT: If a medical emergency should arise while the above named is participating in any Graceway Baptist Church activity, and I cannot be contacted, I hereby give permission to any sponsor of that activity to select a physician and/or hospital for his or her care. I also give the hospital and/or physician, as selected by said sponsor, my permission to hospitalize, treat and order injections to meet the needs of the above named. I will assume responsibility for any and all bills arising from said treatment(s).

In consideration of the permission extended to the above named to participate in the activities of Graceway Baptist Church. I hereby release and hold harmless all employees, staff members and sponsors of Graceway Baptist Church of and from any and all manner of action and causes of actions, judgments, executions, debts, claims and demands of every kind and nature whatsoever, which against them I have had or now have, of which I or my heirs, executors or administrators have now or may hereafter have by reason of the above named participation in Graceway Baptist Church activities, as well as any other operations or incident thereto - by signing below. I declare that the terms of the herein release and information disclosed have been completely read, and are fully understood and voluntarily accepted.

DATE: ______________ DAYTIME PHONE: ______________ CELL PHONE(S) ______________

SIGNATURE: ______________________ RELATIONSHIP: ______________________

OVER

Dear Parents,

Please be advised that NO medication – Prescription and non-presctiption (OTC) can be administered without consent from you. Your signature is required. Should you anticipate your child requiring an over the counter medication such as an Antihistamine, Acetaminophen, Ibuprofen, Tums, etc., please fill out the consent form below.

☐ Check here if you do NOT want your child to receive ANY medication at camp.

Please circle yes or no:

Acetaminophen	325mg for pain or fever. 1 or 2 tablets, 6 to 12 years; liquid per age/weight. May be repeated in 4 hours as needed	yes	no
Ibuprofen	200mg for pain. 1 to 2 tablets; liquid per age/weight. May repeat 4 to 6 hours as needed	yes	no
Benadryl	25mg-50mg for acute allergic reactions. ONLY 1-2 tabs/1-2tsp liquid	yes	no
Tums	1-2 tablets as needed for indigestion (for children in 3rd grade and above)	yes	no
Cough Drops	Lozenge as needed for cough/sore throat (for children in third grade and above)	yes	no

The above medication will be administered, as needed, for the week of children's camp unless otherwise indicated.

I authorize the camp nurse to administer the above medication(s) to:

Child's name: ______________________________

Parent/Guardian's Name: ______________________________

Parent/Guardian's Signature: ______________________________