South Oaks
BAPTIST CHURCH

5925 U.S. HWY 287
Arlington, TX 76017
(817) 478-8284

TRANSPORTATION AND MEDICAL RELEASE FORM

_____ has my permission to attend and to participate in activities sponsored by South Oaks Baptist Church and to be transported to and from activities on vehicles owned by South Oaks Baptist Church and/or operated by drivers approved by South Oaks Baptist Church, between the days of **January 1, 2016** through **January 1, 2017**. I understand that reasonable measures will be taken to safeguard the health and safety of my minor. In case of emergency or illness, every effort will be made to notify me. In case there is a need for treatment, I hereby give my parental consent. I will not hold the church or chaperones personally or financially responsible for any accident or illness that may occur before, during, or after an activity or while being transported to or from an activity.

I hereby grant to South Oaks Baptist Church and to its employees/ agents and assign the right to photograph or video my dependent, and use the photograph/video and/or other digital reproduction of him/ her or other reproduction of his/her likeness for publication processes related to South Oaks Baptist Church whether electronic, print, digital or electronic publishing via the Internet or Social Media.

Signature _____

Address _____

Cell Phone # _____

Day Time Phone # _____

Evening Phone # _____

Date _____

Authorization for medical treatment (on back)

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BAPTIST CHURCH

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Arlington, TX 76017
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AUTHORIZATION for Medical Treatment of Minors

NAME OF MINOR BIRTHDATE ALLERGIES, SPECIAL CONDITIONS, OR MEDICTIONS

_____ _____ _____

I/We being the parent(s) or legal guardian(s) of the above named minor, do hereby appoint:

NAME _____ ADDRESS _____ PHONE _____

NAME _____ ADDRESS _____ PHONE _____

To act on my/our behalf in authorizing unexpected medical, dental, surgical care, and hospitalization for the above named minor while participating in activities sponsored by South Oaks Baptist Church from **JANUARY 1, 2016 to JANUARY 1, 2017.**

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care, or hospitalization may be required.

(You may attach a copy of your insurance card, both front and back, for insurance information)

HOSPITALIZATION COVERAGE FOR ABOVE NAMED MINOR: I.D. OR CONTRACT #_____

INSURANCE COMPANY OR GOVERNMENT PROGRAM _____

ADDRESS FOR INSURANCE COMPANY _____

PARENT EMPLOYEE NAME: _____

WORK PHONE # _____ EMPLOYMENT CITY _____ ZIP CODE _____

GROUP # _____

DATE OF LAST TETANUS SHOT _____ ARE YOU DIABETIC? YES/NO

STUDENT'S SS # _____

FAMILY PHYSICIANS/ PEDIATRICIAN:

NAME _____ PHONE _____

PARENT/ GUARDIAN SIGNATURE _____

DATE _____

STUDENT SIGNATURE _____

DATE _____