



# Annual Permission/Release Form- 2011

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Parents/Guardian Name: \_\_\_\_\_

Child's Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Grade/Year: \_\_\_\_\_

I give permission for the child named above to join the activities of St. John the Baptist Episcopal Church for all outings scheduled and approved by the church business office for the year of 2011. I must be properly informed of all details regarding each outing.

I hereby release St. John the Baptist Episcopal Church, it's staff and sponsors from responsibility and liability from injury or illness that my child may sustain during any activity. In the event of an emergency, I hereby authorize an adult leader of the activity, as an agent for me, to consent to x-ray, examination, medical, dental or surgical diagnosis, treatment and hospital care advised and supervised by a physician, surgeon or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, at a doctor's office or in any hospital. I expect to be contacted as soon as possible if any such emergency should occur.

I will also pick up my child or arrange for his/her transportation home at my expense if the staff or sponsor of St. John the Baptist Episcopal Church deem such action to be necessary in the discipline of my child.

\_\_\_\_\_  
Father/Mother/Guardian Signature

\_\_\_\_\_  
Date

Emergency Contact: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Relationship to child: \_\_\_\_\_

## Notary

In Witness Whereof, I have hereunto set my hand and affixed my notarial seal this:

\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. My commission Expires : \_\_\_\_\_

Notary Public: \_\_\_\_\_

# Medical Information

Date of last MMR Booster: Month: \_\_\_\_\_ Year: \_\_\_\_\_

Date of Hepatitis B vaccination: Month: \_\_\_\_\_ Year: \_\_\_\_\_

Date of last tetanus toxoid immunization Month: \_\_\_\_\_ Year: \_\_\_\_\_

Are all other vaccinations up-to-date: Yes or No

List any conditions the minor is currently being treated for:

\_\_\_\_\_

\_\_\_\_\_

List all current medications:

\_\_\_\_\_

\_\_\_\_\_

List any restrictions on activity: \_\_\_\_\_

List any allergies to:

Food: \_\_\_\_\_

Drugs: \_\_\_\_\_

Do you have (check box):

Sinus Trouble/Hay Fever

Diabetes

Heart Trouble

Epilepsy

Asthma

Explain other medical needs: \_\_\_\_\_

# Insurance Information

PCP Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Group #: \_\_\_\_\_