

# First Baptist Church, Pinehurst, NC Youth Liability Release and Insurance Form

\_\_\_\_\_ Year

## PARTICIPANT INFORMATION

Participant's Name \_\_\_\_\_  
Permanent Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_

email \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_  
Home Phone \_\_\_\_\_

## MEDICAL EMERGENCY CONTACT INFORMATION

Person to Contact First  
Name \_\_\_\_\_  
Relation to Participant \_\_\_\_\_  
Daytime Phone \_\_\_\_\_  
Evening Phone \_\_\_\_\_  
E-mail \_\_\_\_\_  
Name of Family Doctor \_\_\_\_\_  
Name of Dentist \_\_\_\_\_

Backup Contact (Relative or Friend)  
Name \_\_\_\_\_  
Relation to Participant \_\_\_\_\_  
Daytime Phone \_\_\_\_\_  
Evening Phone \_\_\_\_\_  
E-mail \_\_\_\_\_  
Office Number \_\_\_\_\_  
Office Number \_\_\_\_\_

## INSURANCE POLICY INFORMATION

The above-named participant is covered by health insurance.  Yes\*\*  No\*

\* If no, initial this line stating that you do not have health insurance and are aware that First Baptist Church does not carry any health insurance for you.

\*\* If yes, provide the following information which is required by First Baptist Church to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name \_\_\_\_\_ P.H.'s Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Relation to Participant \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Occupation \_\_\_\_\_  
P.H.'s Employer's Name/Address \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_  
Policy # \_\_\_\_\_ Plan # \_\_\_\_\_

## HEALTH INFORMATION (Please Print)

Does the child have any of the following conditions or a history of any of the following conditions? (**Check all that apply.**)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Bronchitis                              | <input type="checkbox"/> Fainting Spells                           |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Ear Infections                          | <input type="checkbox"/> Heart or cardio-vascular problems/disease |
| <input type="checkbox"/> Convulsions/seizure | <input type="checkbox"/> Hay Fever                               | <input type="checkbox"/> Chronic bone, muscle or joint injuries    |
| <input type="checkbox"/> Migraine headaches  | <input type="checkbox"/> Other condition(s): (Please list) _____ |  |

Allergies or reactions: (**Check all that apply.**)

- |   |   |   |                                 |                                  |
|---|---|---|---------------------------------|----------------------------------|
| <input type="checkbox"/> Aspirin                | <input type="checkbox"/> Penicillin           | <input type="checkbox"/> Dairy              | <input type="checkbox"/> Gluten | <input type="checkbox"/> Peanuts |
| <input type="checkbox"/> Insect bites or stings | <input type="checkbox"/> Ivy/oak/sumac toxins | <input type="checkbox"/> Other (list) _____ |                                 |                                  |

Is your child currently on any prescribed or over-the counter medication? (If so, please record the condition/ailment, name of medication, dosage, time(s) of day, prescribing physician.)

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

.....  
Date of last tetanus shot (approximate if necessary): \_\_\_\_\_

(over)

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**TO BE READ AND SIGNED BY PARTICIPANT**

**BEHAVIOR EXPECTATIONS OF THE PARTICIPANT**

It is important to follow the directions of the adult leader(s) at all times. I understand that as a participant I have the responsibility to help make the activity a safe experience for everyone through my behavior and conduct. I also understand the danger of not following rules and directions and agree to follow them.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

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**TO BE READ AND SIGNED BY PARENT OR GUARDIAN**

I understand that my child must be healthy and reasonably fit in order to safely participate in First Baptist Church activities and that I will inform the program leader(s) of any medication, ailment, condition, or injury that may affect his/her ability to participate safely.

**MEDICAL EMERGENCY PARENTAL PERMISSION\***

The health history for my child is correct and complete to my knowledge. If an injury or other medical condition occurs or arises, I hereby give permission to the PFBC staff or volunteer to provide routine health care and seek emergency treatment including x-rays or routine tests. I agree to the release of any record necessary for treatment, referral, billing or insurance purposes. I understand that I am financially responsible for charges and hereby guarantee full payment to the attending physicians or health care unit. In the event of an emergency where I cannot decide for my child, I give permission to the physician/hospital selected by the PFBC staff or volunteer to secure and administer treatment for my child, including hospitalization.

\_\_\_\_\_initial \_\_\_\_\_date

**PFBC ASSUMPTION OF RISK AND RELEASE OF LIABILITY (*Please read carefully.*)**

I give permission for \_\_\_\_\_ to participate in any of the First Baptist Church, Youth activities. I understand that these activities/events may involve certain risks of physical activity and possible injury and that First Baptist Church will provide each participant with reasonable care, but that FBC cannot guarantee that my child will remain free of injury. I agree to RELEASE from LIABILITY, INDEMNIFY and HOLD HARMLESS the First Baptist Church of Pinehurst and any staff and volunteer leaders from any and all claim and/or cause of action arising out of and related to any injury, loss, penalties, damage, settlement, costs or other expenses or liabilities that occur as a result of my child's participation in program.

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

(Must be signed by the parent or guardian if the participant is under 18 years old)

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