

Grade: _____ Name: _____ / _____ / _____
(2023-2024) (Last) (First) (Middle)

FBCSP Kids 2023 - 2024 Information and Medical Release Form

Student's Name _____ Date of Birth ____ / ____ / ____
Last First Middle Initial

Address _____
Street City State Zip

Primary Phone Number _____

Grade for 2023-2024 _____ School _____

Parent/Guardian _____ Relationship to Student _____
Last First Mid. Init.

Address _____
Street City State Zip

Mother:
Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____

Father:
Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____

Medical History of Student

Dietary Allergies (gluten, dairy, nuts, etc.) _____

Drug Allergies _____

Allergic to Bee Stings? ____ Yes ____ No

General Allergies _____

Medications _____

Special Health Problems, Concerns, and/or Instructions _____

Insurance Information for Student

Insurance Company _____ Phone Number _____

***** Please attach a copy of the front and back of your insurance card. *****

Policy Number _____ Group Number _____

Physician _____ Phone Number _____

Address _____

Dentist _____ Phone Number _____

Address _____

Permissions

I do hereby certify that my child, _____, has permission to participate:

In all planned activities for FBCSP Kids _____ Yes _____ No Initial _____

In playing on the playground at FBCSP _____ Yes _____ No Initial _____

In photographs on the church website, church social media,
church live stream, and church publications
(please note: the child's name will not be used) _____ Yes _____ No Initial _____

I understand that it is the expectation of First Baptist Church that my child will remain for the duration of the scheduled event unless they, or their parents, notify the adult leadership of the event.

I understand that First Baptist Church does not carry accident or medical insurance on participation volunteers. I agree that my insurance company will be used for such medical care expenses. I am aware that I may be billed by the medical provider for any medical treatment expenses not covered by my insurance and that I am responsible for the payment of any medical bills.

In the event of an emergency or non-emergency situation in which medical treatment is required as a result of participation with First Baptist Church, every reasonable effort will be made to contact the persons listed on the reverse side. If unsuccessful in contact the persons listed, consent/permission is give for treatment of competent medical personnel.

Signature of Parent/Legal Guardian _____

Date Signed _____

Certificate of Acknowledgement

State of _____

County of _____

On _____, before me, _____, personally
appeared, (date) (notary)

_____, personally known to me.
(signer)

WITNESS my hand and official seal

My Commission Expires:

(seal)

(notary signature)

Please bring this completed form to the church office or mail to:
Mrs. Lauren Craig - First Baptist Church, 200 East New York Avenue,
Southern Pines, NC 28387