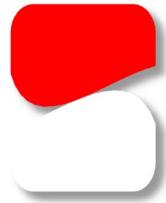




# Shores Student Ministries

## 2017 Medical Release Form



Name: \_\_\_\_\_ Sex (M/F): \_\_\_\_\_

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Weight \_\_\_\_\_ (for medication dosage)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_

Relationship to student: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell # \_\_\_\_\_

Complete ALL of the following information. **Attach a copy of your insurance card.**

Medical Ins. Co.: \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialty Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last Tetanus Shot: \_\_\_\_\_

Allergies, physical limitations, medical concerns: \_\_\_\_\_

\_\_\_\_\_

List of **current prescription medications** student is taking

Medication	Ordering Physician	Dosage	Special Instructions

List of **current over the counter (OTC) medications** student is taking:

OTC Medication	Dosage	Special Instructions

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**Complete back of form also**

Please **circle** whether or not you give permission for these over the counter meds to be given to your student.

Tylenol	Okay to give	Do not give
Ibuprofen	Okay to give	Do not give
Benadryl	Okay to give	Do not give
Claritin	Okay to give	Do not give
Pepto Bismol	Okay to give	Do not give
Cough syrup	Okay to give	Do not give
Drops for swimmers ear (OTC)	Okay to give	Do not give

## ***Emergency Authorization & Liability Release***

I hereby give permission to medical personnel selected by the Student Ministries Pastor or one of the chaperones to order X-rays, routine tests, and treatment for my child. In the event of an emergency and neither the secondary contact nor myself can be reached,

I hereby give permission to the physician selected by the Student Ministries Pastor or one of the chaperones to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery for my child as named above.

I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company.

In addition, I have, and do hereby, release Atlantic Shores Baptist Church, its staff, or volunteers from all liability associated with transportation and/or participation in this activity.

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**Signature of Parent/Guardian**

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**Date**

**Shores Student Ministries  
Atlantic Shores Baptist Church  
1861 Kempsville Road  
Virginia Beach VA 23464  
757 479-1133**