Student____________________

HIGH SCHOOL DEPARTMENT
Brian Holland, Pastor

RESPONSIBILITY RELEASE FORM

We the parents or guardians of ______________________Grade ___________ authorize the First Baptist Church of Pomona to act as agents and to use their own initiative and discretion in the case of accident involving the person named on this form.

If necessary or deemed advisable because of illness or accident, agents of First Baptist Church shall authorize X-ray examination, medical diagnosis or treatment, and/or hospital care, advised by any physician or surgeon licensed under the Medical Practices Act.

By this authorization, advance notice is given to provide by my/our specific consent, any treatment or hospital care necessary in case of such illness or accident.

This permission includes dental treatment (if necessary) to be performed by a dentist licensed under the Dental Practices Act.

First Baptist sponsoring agents shall have prior information on any participants in church activities that are subject to extreme physical disabilities and/or limitations.

The above authorization shall be effective from January 1, 2010 to December 31, 2010 unless revoked and delivered to First Baptist Church prior to the effective dates.

BEHAVIORAL STATEMENT

I understand that my child will be expected to follow all rules and regulations, set up by the church and the staff in charge of this group's trips. If my child becomes a behavioral problem and it is deemed necessary by this staff for my child to return home, I will arrange it at my own expense.

Parent Signature ________________________________ Date ___/___/____

Address ____
(Street Number) (City) (Zip)

Telephone: Home # ___________________

Parent Work ___________________

Parent's Cell ___________________

Students Cell ___________________

FIRST BAPTIST CHURCH OF POMONA
Medical Consent Form

Parent's Name ____

Student's Name ____________________________________ Birthday ___/___/___

Address (if different from front) ____________________________________ Grade_________

City ______________________________ State _____________ Zip ____________

Parent's Phone No. (Hm.) (____)__________________ (Wk.) (_____)_________________

Student's E-mail ____

Parent's E-mail ____

Name of School ____

Health Information

Insurance Carrier ____

Group No. _____________ Policy No. _____________ Telephone No. ___________

Allergies

__Drug Allergies	__Diabetes	__Physical Handicap
__Asthma	__Cardiac	__Emotional Handicap
__Hayfever	__Chronic Asthma	__Seizure Disorder
__Insect Stings	__Nervous Disorder	__Other
__Other	__Epilepsy	

If you have checked any of the above, please give details _______________________

____

Does your child have an activity restriction? Please explain _____________________

____

Medication being sent ____

This health information is correct, so far as I know, and the child herein described has permission to engage in all activities, except as noted.

In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the leader of this group, to hospitalize, to secure proper treatment and/or to order an injection, anesthesia or surgery for my child, as necessary.

I authorize the leader/person in charge to administer aid as requested by physician.

______________________ ____________________________

(Dated) (Signature of Parent/Legal Guardian)

(This medical consent form covers the time period appearing on front side)