PLEASE RETURN! THIS FORM IS GOOD FOR ALL 2022 TRIPS!

Medical Consent/Media Release Form

First Baptist Church, 3500 Walton Way Ext., Augusta, GA 30909
706.733.2236 www.fbcaugusta.org

Name_____

PERMISSION CLAUSE: By my signature below I am agreeing that if my child_____ becomes ill or sustains injury while on an outing with First Baptist Church of Augusta or while attending an event hosted by First Baptist Augusta, I give my permission to the staff or representative of FBC Augusta to administer first aid and or take him/her to the nearest medical facility for additional treatment. I am also agreeing to not hold First Baptist Church Augusta, any of First Baptist Augusta's ministers, or any chaperone personally or financially responsible for any accident or illness that may occur.

PHOTO RELEASE AGREEMENT: I further understand that photographs or video recordings may be created during these events (including Sunday and Wednesday activities), and I give permission for First Baptist Church Augusta to use any or all recordings of my child in publications, videos, website design, or other media expressions (including social media). I waive all rights to control any aspect of these photographs and recordings.

DISCIPLINARY AGREEMENT: I understand that it may become necessary to send my child home for disciplinary reasons. By my signature below, I agree to assume responsibility for any cost incurred. Also, by my signature below I am agreeing to assume responsibility for doctor bills, telephone calls, and other expenses relating to an emergency.

MEDICAL INSURANCE AGREEMENT: I hereby confirm that my child is covered and will remain covered under a medical insurance policy. If my coverage changes, I will promptly notify First Baptist Church Student Office 706-733-2236 x 204. I further agree that my insurance company will be the primary source of coverage in case of injury or illness held at or sponsored by First Baptist Church involving my child and that I am responsible for any deductible expenses in connection with that coverage.

Primary Insurance Company_____ Company's Phone number_____

Company's Address_____ City_____ Zip_____

ID#_____ Group/Policy #_____

Policy Holder's Name_____

Policy Holder's Address_____ City_____ Zip_____

Home Phone Number _____Cell Phone _____ Work_____

Email Address_____

List below all known medical conditions, including food allergies, drug allergies, and any other medical allergies (bee stings, poison ivy, etc.) In addition, list any over-the-counter and or prescription drugs taken regularly.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please make a copy of your insurance card (front and back) and return with this form.

_____ _____
(Signature of student) Date signed

_____ _____
(Signature of Parent or Legal Guardian) Date signed