



Cornerstone Baptist Church
Student Ministry Medical Release Form

Cornerstone Baptist Church
On Fire Student Ministry
2930 Masters Way
Darlington, SC 29532

Phone (843) 395-1370
Fax (843) 395-1377

To be filled out by Parent or Guardian only:

We, the undersigned parent(s) or legal guardian(s) for _____,
do release, forever discharge and agree to hold harmless Cornerstone Baptist Church and
its representatives thereof from any and all liability, claims, or demands for personal
injury, sickness, or death, as well as property damage and expenses of any nature
whatsoever which may be incurred by my child in the course of participation in
Cornerstone Baptist Church activities. We give authorization for Cornerstone Baptist
Church to provide all necessary food, transportation, and lodging. We give our permission
for our child to participate in Cornerstone Baptist student activities and for any adult
representative of the church to obtain necessary medical treatment. We, the parents or
guardians, assume responsibility for any medical bills incurred. Should our child have to
return home before the group for medical or disciplinary reasons, we hereby assume any
costs incurred.

Parent or Guardian

This agreement authorizes any licensed hospital or professional to render
medical/surgical care as deemed necessary for the emergency.

Parent or Guardian Date

Notary Commission expires

BOTH SIDES MUST BE COMPLETED

* I have read and understand the On First Student Ministry Allergy/Medication Policy.

(sign here)

General Information (*Please Print*)

Name: _____ Male: _____ Female: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Birth Date: _____ Age: _____ Grade: _____ School: _____

Student Cell: _____ Father Cell: _____ Mother Cell: _____

Email Address: Student _____

Parent _____

Health Information

Father's Name: _____ Occupation: _____ Work Number: _____

Mother's Name: _____ Occupation _____ Work Number: _____

In an emergency, please notify (other than yourself):

_____ Relationship: _____ Phone Number: _____

_____ Relationship: _____ Phone Number: _____

Family Doctor: _____ Phone Number: _____

Insurance Carrier: _____ Policy Number: _____

Are there any physical or medical conditions or restrictions? Yes _____ No _____

If yes, please explain and indicate nature and extent:

Any known allergies or allergic reactions?

Last tetanus shot: _____ May aspirin be given? Yes: ___ No: ___

May your child be given acetaminophen (such as Tylenol)? Yes: _____ No: _____ Others

May your child be given a stomach ache remedy such as Pepto Bismol? Yes: ___ No: ___

Any other condition that would be helpful in treating your child?

Parent or Guardian Signature: _____ Date:

____/____/____