

# INFORMATION / MEDICAL / PERMISSION FORM

Woodburn Baptist Church, PO Box 38, Woodburn, KY 42170

Franklin Campus, 822 Blackjack Rd, Franklin, KY 42134

## WBC Youth Trips

*Please Print*

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ School Year \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Cell \_\_\_\_\_

Place of Employment \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Cell \_\_\_\_\_

Place of Employment \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance No. \_\_\_\_\_

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

Address \_\_\_\_\_

Dentist / Orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Notify in case parents cannot be reached \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Are you allergic to any medicines? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list \_\_\_\_\_

Are you allergic to any insect bites or stings? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list \_\_\_\_\_

Are you presently taking any medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list \_\_\_\_\_

Do you have any other medical condition or food allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe and list treatment \_\_\_\_\_

### RELEASE CLAUSE

In the event of an accident, I hereby authorize the representative of Woodburn Baptist Church to secure and provide emergency medical care. Permission is granted for first aid to be administered, and /or treatment to be given. I/We, the undersigned do hereby release, remiss and forever discharge all sponsors and Woodburn Baptist Church, 600 Woodburn Allen Springs Rd, Woodburn KY and/or Franklin Campus, 822 Blackjack Rd, Franklin, KY from any and all claims, demands, actions or cause of action, past or present, or future arising out of all damage or injury while participating in the event.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_