MEDICAL RELEASE
Lake Hills Baptist Church

Child's name ____ Age ________

Parent's name ____

Address ____

____

Address of child if different from above:

____

Home phone _________________________

Cell phone __________________________

Alternative contact person ____

Relationship ______________________________ Phone ________________________

I hereby authorize the emergency medical treatment of my child while under the care and custody of Lake Hills Baptist Church and hold harmless the church and its agents or assigns and representatives, including volunteer workers for any harm deemed to arise from the said treatment or the lack of said treatment.

I understand that Lake Hills Baptist Church nor its workers are responsible for administering any medications required to be taken by my child and this is the sole responsibility of my child; and I acknowledge that Lake Hills Baptist Church nor any of its workers are authorized to make any medical diagnosis nor administer any medical procedures, excepting those actions deemed proper and necessary in an emergency where they may act as a "Good Samaritan" and render aid and assistance as allowed under the laws of Indiana, whose jurisdiction is agreed to by myself as applicable.

A copy of this document shall be valid as though it were an original.

Date: ____________________ Signature:____

Printed:____

Child's Full Name:_________________________ **Date of Birth:**__________________

Medical Insurance Co.:______________________ **Policy #:**______________________

Doctor's Name: ___________________________ **Phone #:**______________________

Special Needs or Medical Concerns:____