TBC STUDENTS | Medical/Photo/Video Permission & Release Form // Expires December 31, 2020

Today's Date: _____
Student's Name: _____ Gender: M/F Grade: _____
Address: _____ Birthdate: _____ Age: _____
City: _____ State: _____ Zip Code: _____
Mom's Name: _____
Dad's Name: _____
Emergency Contact: _____ **Phone:** _____
Family Physician: _____ Phone: _____
Insurance Company: _____ Policy #: _____
Immunizations: ___ Tetanus ___ Polio ___ Measles ___ Mumps
Allergies: Food: _____
Drugs: _____
Insect Stings/Bites: _____
Poison Sumac, Oak, Ivy: _____
Conditions/Serious Illness/Operations: _____
Current Medication: _____
Special Diet: _____
Childhood Diseases: ___ Chickenpox ___ Measles ___ Mumps ___ Whooping Cough ___ Other (List Below)

_____

Statement of Consent *(To be signed in the presence of a legalized notary public)*

My permission is granted to Tabernacle Baptist Church to obtain necessary medical/dental attention in case of sickness or emergency to my child.

I understand that as a participant, my child may be photographed or videotaped during normal camp or event activities and these photos/videos may be used in promotional materials, church publications, or on the church website. I understand that this form is in effect from the date signed and that it is my responsibility to inform Tabernacle Baptist Church of any changes to this form.

I, the undersigned, do verify that the above information is correct and I do hereby release and forever discharge all sponsors and the Tabernacle Baptist Church from any and all claims, demands, actions or cause of action, past, present, or future arising out of any damage or injury while employed by or participating in an activity.

_____ _____
Parent or Guardian Signature Date

Notarization

On this _____ day of _____, _____, _____
(date) *(month)* *(year)* *(name of parent/guardian)*
personally appeared before me in _____ County (in the state of _____) and, in my presence, signed this release form.

Name of Notary Official: _____

Signature: _____

Commission Expires: _____