

**THIS PAGE WILL NEED TO BE PRINTED AND
SIGNED
IN THE PRESENCE OF A NOTARY PUBLIC**

PARTICIPANT'S MEDICAL INFORMATION

Full Name of Participant: _____ Participant's S.S.#: _____
Date of Birth: _____ Address: _____ City _____ State _____ Zip _____
Name of Parent/Guardian: _____ Phone #: _____
Relationship to Participant: _____ Alternate Phone: _____

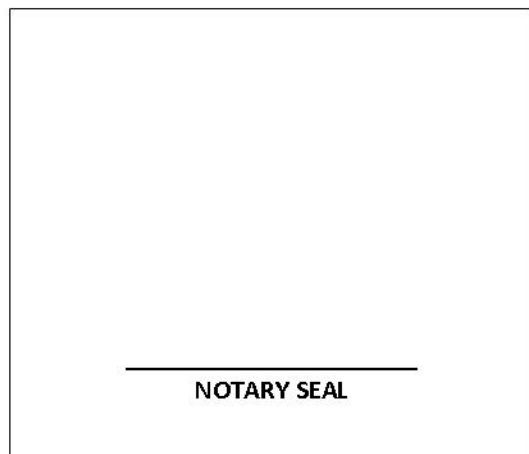
As parent/legal guardian of _____, I do hereby authorize my consent to any X-ray, examination, anesthetic, medical or surgical diagnosis rendered under general or special supervision of any licensed medical staff member under the provision of the Medicine Practice Act. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required, but is given to provide authority and power to render care which the aforementioned physician, in his or her best judgment, may deem advisable. It is understood that effort shall be made to contact me, the undersigned, prior to rendering treatment to my child, but that any of the above treatments will not be withheld if I cannot be reached. I agree to be responsible for paying any charges that may be incurred by such treatment. I hereby release Central Baptist Church of Martin, Tennessee, its staff, and representatives from any liability for accidents or injury sustained by my child in conjunction with any event.

MEDICAL INSURANCE INFORMATION

Insured Parent/Legal Guardian's Name: _____ S.S.#: _____
Insurance Company: _____ Phone: (____) _____ Group/Policy#: _____
Family Physician: _____ Doctor's Phone # (____) _____ Last Tetanus/DPT immunization date _____

(*PLEASE DO NOT SIGN BELOW UNLESS YOU ARE IN THE PRESENCE OF A NOTARY*)

Signature of Parent/Legal Guardian _____ Date _____



NOTARY ACKNOWLEDGEMENT
Subscribed and sworn to before me,
a Notary Public in and for
_____ County, Tennessee on this
____ day of _____, 20____

(Signature of Notary Public)
My Commission expires

(Date)