Medical Information and Release Form for -2026

Anastasia Baptist Church, 1650 A1A South, St. Augustine, Florida 32080

Name of Participating Child:		Age:	Birth Date:
Address	City	State	Zip Code
Parent information:			
Email:		Home Phone	
Father (Guardian) Name:		Cell Phone:	
Mother(Guardian) Name:		Cell Phone:	
Hospital Insurance oYes oNo	Insurance Company	Policy Number	
Policy Holder	Group Number	Policy Holder Date of Birth	
Physician's Name:	Phone:		
In case of Emergency when parents are unreachable Notify:			
Name:	Phone:		

RELEVANT MEDICAL HISTORY

In the past, or presently, the participant has been treated for, suffered from or engaged in:
Check where appropriate and supply any necessary additional information.

Asthma
Asthma Medication
Diabetes
Insulin Dependent
Kidney Trouble
Heart Trouble
Bronchitis, Sinusitis
Stomach, Gastrointestinal Problems
Dizziness
Hearing Impaired
Visually Impaired

Childhood Diseases

Mumps
Chicken Pox
Measles
Whooping Cough
Other:_____

Please List Any:

Allergies:

Drug Allergies::

Food Allergies::

Insect Sensitivities:

Previous Surgeries:

Chronic Infectious Illness or Disease:

Special Medical Information:

Special Medications:

Special Diet:

PLEASE LIST ANY/ALL MEDICATIONS_____

_____

_____

I hereby authorize employees, representatives or authorized event leaders from Anastasia Baptist Church in whose care the minors named above have been entrusted to consent to appropriate and reasonable medical care as recommended by a treating medical doctor including but not limited to X-ray examination, anesthetic, medical, surgical diagnosis, treatment or hospital care, to be rendered by a duly licensed medical practitioner. The undersigned shall be fully liable to and agree to pay all costs and expenses in connection with such medical services rendered to the child.

This document will be considered valid during the time period beginning January 1, 2026 until December 31, 2026

I hereby certify that the medical history provided on this document is correct. I understand that it is the duty of the parent/guardian to make any necessary additions to the medical history, if necessary.

_____ **X**_____ _____

Printed Name of Parent (Guardian) **Signature of Parent (Guardian)** **Date**

NOTARY CERTIFICATION

On this the ___ day of _____ of _____, the above person personally appeared before me _____
(Printed Name of Notary Public)

and in my presence executed the within and foregoing release form. Witness by my hand and official seal this _____ day of _____, _____.

My commission expires _____ . Notary Public :_____

Event Copy (take on trip) **Copy for File**