MEDICAL WAIVER

NOTICE: This form must be completed and brought to the event **for anyone under the age of 18** in order for that student to be able to participate in a Collegiate Ministries sponsored activity or event. This form must be signed by a parent or guardian and notarized in the spaces provided. **A COPY OF THE FRONT AND BACK OF THE APPROPRIATE INSURANCE CARD MUST BE ATTACHED.**

Participant's Information

Last First Middle Prefer to be Called

Age Date of Birth Soc. Sec # Church

Street Address City State Zip

IN CASE OF AN EMERGENCY, NOTIFY ONE OF THE FOLLOWING IN THE ORDER LISTED

1. Name Relationship Work Phone Home Phone Cell Phone/Pager

2. Name Relationship Work Phone Home Phone Cell Phone/Pager

3. Name Relationship Work Phone Home Phone Cell Phone/Pager

Parent/Guardian Information

1. Last First Middle Relationship

Street Address City State Zip

Church Soc. Sec # Work Phone Home Phone Cell Phone/Pager

2. Last First Middle Relationship

Street Address City State Zip

Church Soc. Sec # Work Phone Home Phone Cell Phone/Pager

Medical Power of Attorney and Release

I, _____, hereby acknowledge under oath that I am the parent or guardian of _____ ("my child"), and, unless I otherwise state in writing, I hereby give permission for my child to participate in events and activities conducted, sponsored, and/or organized by the Collegiate Ministries of Georgia Baptist Mission Board. As an integral part of such permission, I recognize that the Georgia Baptist Convention is a nonprofit organization whose purpose is to share the Gospel of Jesus Christ and is not in the business of providing entertainment events and activities for youth.

Therefore, I hereby agree to hold the Georgia Baptist Mission Board, including Collegiate Ministries, its employees, representatives and agents, harmless from and against any and all claims, demands, liabilities, actions, causes of action, damages and/or expenses, of any nature and kind and without limitation, arising from personal injuries to my child or property damage, either resulting directly or indirectly from my child's participation in the Collegiate Ministries programs. I hereby acknowledge that I assume the risk of any and all personal injury or property damage that may occur to my child, that I will hold the Georgia Baptist Mission Board Collegiate Ministries completely and totally harmless concerning any such injury or damage, that I hereby waive any cause of action or right to cause of action that I might have against the Georgia Baptist Mission Board Collegiate Ministries or that might thereafter accrue as a result of such injury or damage, and that I have has an opportunity to review this waiver and ask any question concerning its meaning or intent.

In the event my child is injured or becomes ill during a Georgia Baptist Mission Board Collegiate Ministries event or activity, I hereby grant permission for (1) the Event Administrator, (2) any employee or representative, or (3) the person(s) in charge of First Aid to obtain and/or provide for my child necessary medical attention and treatment, including but not limited to emergency medical care provided by a hospital, medical clinic, or other emergency health care provider.

I verify that I have read this entire document, have had reasonable opportunity to ask questions concerning its application, understand its contents, and acknowledge that the various information provided throughout this document is accurate and complete. I further acknowledge and verify that I have full legal authority to execute this document and that there are no requirements, conditions, or obligations, legal or otherwise, which would require the consent or assent of any other person or entity.

Signed this the _____ day of _____, 20____.

_____
Signature of Parent or Guardian

Notary Public

I, the undersigned officer duly qualified and authorized to administer oaths, do hereby state and affirm that _____ personally known by me, appeared before me and in my presence executed the above and foregoing Medical Waiver together with its Medical Power of Attorney and Release. Witness my hand and seal this _____ day of _____, 20_____.

_____
Notary

NOTARY SEAL

My commission expires _____

Participant's Medical Profile and History

☐ Please check this box if additional information is attached to this form.

Generally, my child's health is: (check One) _____ Excellent ____ Good _____ Fair _____ Poor
If Fair or Poor, please explain why:

_____
_____
_____
_____

Check the following conditions or diseases your child has had or currently has:

_____ ADD/ADHD	_____ Anemia	_____ Anxiety Attacks
_____ Appendicitis	_____ Asthma	_____ Bronchitis
_____ Chickenpox	_____ Chronic Headaches	_____ Diabetes
_____ Diagnosed Phobias	_____ Dizziness/Fainting	_____ Epilepsy
_____ GI/Stomach Disorder	_____ Hay Fever	_____ Heart Disorder
_____ Hyperglycemia	_____ Hypoglycemia	_____ Hypertension
_____ Hypertension	_____ Influenza	_____ Kidney Disorder
_____ Measles	_____ Meningitis	_____ Migraines
_____ Mumps	_____ Pneumonia	_____ Pleurisy
_____ Polio	_____ Sinusitis	_____ Tetanus
_____ Thyroid Disorder	_____ Tuberculosis	

Are there any other conditions or diseases that your child currently has or for which your child is receiving treatment? These may include psychological conditions as well as physical conditions. If so, please specify the condition and the treatment, if any, your child is receiving.

_____

Please list all allergies that your child may have. These may include allergies to certain food, medication, insect bites or stings, pollen, plants, or animals.

_____
_____

Please describe any other special medical needs or conditions that your child may have. These may include significant hearing, sight or speech impairments, various physical disabilities, restricted diets, etc.

_____
_____

Please list any major operations your child has had and give the approximate date of the surgery.

_____
_____

Please list any prescribed medication(s) your child is currently taking.

_____
_____

Family Physician:

_____
Name Office Phone No.

_____
Address

Other Physician:

_____
Name Office Phone No.