

# MEDICAL RELEASE & AUTHORIZATION TO PICK UP FORM

## Children's Ministry

Mayfield Road Baptist Church ~ Arlington, Texas

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Month/Day/Year

Home Address: \_\_\_\_\_ TEXAS \_\_\_\_\_  
Street City State Zip

Parents/Legal Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Person to Contact in Case of an Emergency: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

Additional Medical Information: \_\_\_\_\_

### Medical Release

In the event of an emergency and/or any situation where medical treatment may be required, I give my permission to the Children's Minister, Church Staff, or any Sponsor associated with Mayfield Road Baptist Church to obtain the services of a licensed physician. I realize that there will be an immediate attempt to notify me concerning such an emergency. If I am unavailable for immediate contact, I realize that there will be continued attempts to notify me while medical treatment is underway.

Insurance Group and Policy Number: \_\_\_\_\_

Hospital (in case of emergency): \_\_\_\_\_

Doctor's Name \_\_\_\_\_

### Authorization to Pick Up

The name(s) of the following persons are authorized to pick up my child.

**Note:** Authorized persons to pick up preschoolers should be at least 18 years old.

Name	Address	Phone

I give my permission for MEDICAL TREATMENT and AUTHORIZATION for PICK UP for my child.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date