Pleasant Grove Baptist Church
Medical Release and Liability Waiver Form

This will be kept on file for one year.
This form may be mailed to or dropped off with your payment of $25 and Blitz Football Registration Form at Pleasant Grove Baptist Church:
Blitz Football Camp
Pleasant Grove Baptist Church
1002 S. Buncombe Rd.
Greer, SC 29651

The purpose of this form is to provide information in the event of an emergency, permission to seek medical treatment, and parent consent to do so.

Youth's Full Name: _____

Birth date: _____ Grade in School: _____

Parents'/Guardians' Names: _____

Home address: _____
Street City State Zip code

Phone: _____
Home Mother-work Father-work

Optional: _____
Mother-cell Father-cell

We (I) the parents/guardians of _____ a minor, after failed attempts to contact us (me) do hereby authorize our/my child's group leader or youth counselor of Pleasant Grove Baptist Church to consent to any x-ray, anesthetic, medical, surgical, and dental diagnostic or treatment as may be considered necessary by the physician, surgeon, dentist or other health care personnel for such minor child.

The undersigned shall be liable and agree(s) to pay all cost in connection with medical treatment of our (my) child.

We (I) further release Pleasant Grove Baptist Church and any members of its governing boards and committees, pastors, employees, staff counselors, and volunteers acting on behalf of and of the above, for any and all liability, claims, suits, cause of action and demands, at law or in equity, and however arising, for personal injuries and damages which may be incurred by our (my) child and/or ourselves while such child attends, participates in, or travels to and from, any youth activities sponsored by, or affiliated with the youth ministry program of Pleasant Grove Baptist Church.

Signature of Parent /Guardian:_____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(Both Parents/Guardian sign)

Over

Insurance Information

Health Insurance Company: _____

Insurance Policy or Group Number: _____

Insurance Company Phone Number: _____

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Emergency Contacts

(Please provide 2)

Emergency Contact Name: _____

Relationship:_____ Phone:_____

Emergency Contact Name: _____

Relationship:_____ Phone:_____

Other Information

Does youth participant have/subject to/reaction to: (If yes please explain)

Yes	No	
___	___	Allergies? _____
___	___	Heart Conditions? _____
___	___	Headaches? _____
___	___	Seizures? _____
___	___	Motion Sickness? _____
___	___	Fainting? _____
___	___	Sleep walking? _____
___	___	Upset Stomach? _____
___	___	Bee stings? _____
___	___	Penicillin? _____
___	___	Other Drugs? _____
___	___	Poison Ivy/Oak/Sumac? _____
___	___	Asthma? _____