



# **Waiver and Medical Release Form 2003**

**Please Print, Sign and Return to Braden Park Baptist Church Staff or Sponsor  
4739 East 5<sup>th</sup> Street Tulsa, Oklahoma 74112.2716  
Telephone: 918.834.3378**



I, (legal parent or guardian) \_\_\_\_\_ agree that (youth) \_\_\_\_\_ may participate in the events sponsored by Braden Park Baptist Church. In consideration of participation in this event, I agree, on behalf of the above named child, his/her heirs and representative to fully and forever release, discharge, indemnify and hold harmless Braden Park Baptist Church, Tulsa, Oklahoma, its agents, servants and employees from any and all claims, demands, damages, rights of action or causes of action, present or future, whether the same be known, anticipated or unanticipated, resulting from or arising out of participation in this event. I HEREBY AUTHORIZE IN ADVANCE ANY NECESSARY MEDICAL OR DENTAL TREATMENT REQUIRED BY THE ABOVE NAMED CHILD WHILE IN ATTENDANCE OF THIS CAMP. I ALSO ACKNOWLEDGE THAT I HAVE/WILL NOTIFY THE CAMP PERSONNEL OF ANY SPECIAL MEDICAL NEEDS OR INFORMATION REQUIRED BY THE ABOVE NAMED CHILD. Also, I understand that all rules and regulations for the camp/event will be enforced and any violation by my child will result in a call to me with a possible request to come and pick up my child with no refunds being given. I understand that this medical release may be kept on file for future events during the year and it is my responsibility to make any changes or corrections on a new form.

Name and phone number of Parent/Guardian in case of emergency: \_\_\_\_\_

List any dietary restrictions (please be very specific and concise): \_\_\_\_\_

Health History (check all that apply to the applicant):

- |  |   |                                       |  |                                      |
|--|---|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Fainting        | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Measles      | <input type="checkbox"/> Kidney/Bladder Problems | <input type="checkbox"/> Hepatitis   |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Ear Problems     | <input type="checkbox"/> Constipation | <input type="checkbox"/> Convulsions/Seizures    | <input type="checkbox"/> Rubella     |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Broken Bones     | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Bronchial Problems      | <input type="checkbox"/> Chicken Pox |

Other: \_\_\_\_\_

If you checked any boxes above, please explain in detail:

\_\_\_\_\_

List any recent operation, illness or health condition:

\_\_\_\_\_

List current medication, including dosage and frequency:

\_\_\_\_\_

List restricted activities/disabilities:

\_\_\_\_\_

Check allergies:  Bee Sting  Penicillin  Food  Other  
If you checked any of the above, please explain (how serious, which foods, etc.):

\_\_\_\_\_

Current family physician or family doctor (name and phone number):

\_\_\_\_\_

Health Plan (including number) and phone number for emergency referrals: \_\_\_\_\_

\_\_\_\_\_

Please use the space below to share any other concerns you have about your child:

\_\_\_\_\_

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

\_\_\_\_\_  
Date

**EMERGENCY CONTACTS:**

Primary Contact: \_\_\_\_\_ Relation to Camper \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone \_\_\_\_\_

Backup Contact: \_\_\_\_\_ Relation to Camper \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone \_\_\_\_\_

**INSURANCE POLICY:**

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relation To Student \_\_\_\_\_

Address \_\_\_\_\_ Phone# \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy# \_\_\_\_\_ Plan# \_\_\_\_\_

Insurance Company \_\_\_\_\_

Address: \_\_\_\_\_ Phone# \_\_\_\_\_