

Last Name _____

2018 Medical Release & Indemnity Agreement

(Youth: age 17 and younger)

Trinity Baptist Church, Amarillo, Texas

1601 I-40 West

Amarillo, Texas 79109

(806)372.2421 (806)372.2655 fax

As is authorized in Section 32.001 of the Family Code of the State of Texas entitled "Consent by Non-Parent", in the event of an accident or illness concerning, _____, hereinafter MINOR, Trinity Baptist Church, (hereinafter TBC) acting by and through its adult representatives will use its best effort to contact the parent(s) or legal guardian(s) of MINOR as soon as is reasonably possible. In the event the parent(s) or legal guardian(s) is not available, Gary Hendrickson, Minister to Youth for TBC, or any other authorized adult sponsor (paid or volunteer) for TBC, as adults who have the actual care, control, and possession of MINOR shall be authorized by this written document to secure and consent to such medical, dental, psychological, and/or surgical treatment for MINOR as they in their sole discretion shall deem necessary for the treatment of the accident or illness.

I, the undersigned parent or guardian, shall assume full responsibility for all medical bills, doctor bills, and/or hospital bills or otherwise incurred by MINOR. Further, I agree to indemnify and reimburse TBC, Gary Hendrickson, and/or any other agents, employees, sponsors, volunteers, or otherwise of TBC who shall incur such expenses in the treatment of the accident or illness of MINOR the full amount which shall be expended.

I also understand that as a participant in youth events, my child may be photographed or videotaped during normal youth activities, camps, retreats, or events and that these photos or videos may be used in promotional materials by the groups sponsoring such events.

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

Medical Data for Minor Last Name _____

Name of Minor			
Social Security Number - -	Date of Birth / /		
Home Address			
City, State, Zip			
Home Phone	Other Phone		

Father/Guardian Name			
Home Address (if different)	City, State, Zip		
Work Address (if different)	City, State, Zip		
Home Phone	Work Phone		
Mother/Guardian Name			
Home Address (if different)	City, State, Zip		
Work Address (if different)	City, State, Zip		
Home Phone	Work Phone		

Family Physician / Doctor			
Address			
City, State, Zip			
Dr. Emergency Phone			
Medical Insurance Company	Policy Number		
Emergency Phone #	Other Phone		
Address	City, State, Zip		

Current Medication & Dosages		
1.	2.	3.
Known Drug or Food Allergies:		
Other Medical Information:		
Other Relative or Contact in Case of an Emergency		
Name	Phone	
Name	Phone	
Name	Phone	