PARENTAL CONSENT AND MEDICAL RELEASE

TO WHOM IT MAY CONCERN:

The undersigned does hereby give permission for our (my) son/daughter, _____ to participate in First Baptist Church of Pikeville Youth Group, progressive dinner activity on April 26th, 2025. The undersigned does also hereby give permission for our (my) son/daughter to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by First Baptist Church of Pikeville, Tennessee.

We (I) authorize an adult, in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the Medical staff of a licensed hospital and/or emergency care facility, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. We (I) do herewith authorize the treatment by this authority and is granted only after a reasonable effort has been made to reach us/me the parent(s) and/or guardian(s).

We (I) the undersigned shall be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

My signature also serves to indicate my willingness to take full financial responsibility for any and all medical services rendered for the named participant. My signature also serves to indicate my willingness for my **Health Insurance Company**:

Policy number: _____ to be billed for any and all fees and services should they be needed.

We (I) hereby release First Baptist Church of Pikeville, Tennessee Youth Group, pastor, teachers, workers from this liability.

Clubber Name: _____ Date of Birth: _____

Clubber Address: _____

Parent's/Guardian Name _____ Phone Number _____

Family Doctor _____ Doctor's Phone Number _____

Date of Late tetanus shot _____

List any specific medical allergies, such as bee stings, food, dye or drug allergies. Also list any medical conditions, illnesses or medications a physician would need to know:

Emergency numbers (other than those listed above) such as grandparents, aunts, uncles, neighbors and cell phone numbers:

Name	Name	Name	Name
Phone Number	Phone Number	Phone Number	Phone Number

We (I) the parent(s) or guardian(s) of the aforementioned child do hereby acknowledge that the above information is true and give permission for above treatment to be rendered and do not hold the aforementioned parties liable.

_____

_____

Parent or guardian signatures