5925 U.S. HWY 287
Arlington, TX 76017
(817) 478-8284

TRANSPORTATION AND MEDICAL RELEASE FORM

______________________________, ______________________________, ____________________

Has my permission to attend and to participate in activities sponsored by South Oaks Baptist Church and to be transported to and from activities on vehicles owned by South Oaks Baptist Church and/or operated by drivers approved by South Oaks Baptist Church, between the days of January 1, 2008 through January 1, 2009. I understand that reasonable measures will be taken to safeguard the health and safety of my minor (s). In case of emergency or illness, every effort will be made to notify me. In case there is a need for treatment, I hereby give my parental consent. I will not hold the church or chaperones personally or financially responsible for any accident or illness that may occur before, during, or after an activity or while being transported to or from an activity.

Signature ____ Cell Phone # _________________________

Address ____ Day Time Phone # ____________________

____ Evening Phone # ______________________

Date ____________________________

Authorization for medical treatment (on back)

5925 U.S. HWY 287,
Arlington TX 76017
(817) 478-8284

AUTHORIZATION for Medical Treatment of Minors

NAMES OF MINORS	BIRTHDATES	ALLERGIES, SPECIAL CONDITIONS, OR MEDICATIONS
____________________	____________	____
____________________	____________	____
____________________	____________	____

I/We being the parent (s) or legal guardian (s) of the above named minor (s), do hereby appoint:

NAME ____________________________ ADDRESS ____ PHONE _______________________

NAME ____________________________ ADDRESS ____ PHONE _______________________

NAME ____________________________ ADDRESS ____ PHONE _______________________

To act on my/our behalf in authorizing unexpected medical, dental, surgical care, and hospitalization for the above named minor's) while participating in activities sponsored by South Oaks Baptist Church from **JANUARY 1, 2008 to JANUARY 1, 2009.**

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care, or hospitalization may be required.

HOSPITALIZATION COVERAGE FOR ABOVE NAMED MINOR(S): I.D. OR CONTRACT #__________________

INSURANCE COMPANY OR GOVERNMENT PROGRAM ____

ADDRESS FOR INSURANCE COMPANY: ____

PARENT EMPLOYEE NAME: ____

WORK PHONE # ________________ EMPLOYMENT CITY _______________________ ZIP CODE ___________

DATE OF LAST TETANUS SHOT __________________________ ARE YOU DIABETIC? YES/NO

STUDENT'S SS # __________________________ GROUP # ________________________________

FAMILY PHYSICIANS/ PEDIATRICIAN:

NAME ______________________________________ PHONE ______________________________

PARENT/ GUARDIAN SIGNATURE ______________________________________ SS #______________________

ADDRESS _____________________________________ DATE ___________________________________

PARENT/ GUARDIAN SIGNATURE ______________________________________ SS #______________________

ADDRESS _____________________________________ DATE ___________________________________