



River Road Church, Baptist
8000 River Road
Richmond, VA 23229
(804) 288-1131 | www.rrcb.org

Medical Release Form

Participant Name: Age: Date of Birth:

Address:

City: State: Zip Code:

Home Phone: Cell Phone:

Parent(s) or Legal Guardian(s):

Home Phone: Work Phone: Cell Phone: (if different from above)

Medical History:

Medication (currently using):

Allergies (to medication):

Date of Last Tetanus Shot:

Family Doctor:

Address: Phone:

City: State: Zip Code:

Insurance Carrier:

Policy Number:

Emergency Contact (different than parent listed): _____

Relationship: _____

Home Phone: (____) ____ - ____ Work Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____

Please read, fill out, & sign:

I, _____ do hereby give permission for my child,
parent/legal guardian
_____, to receive emergency medical care. In addition, I will not hold River Road Church, Baptist, responsible for any expense, claims, or liability arising from an injury to my child. In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by River Road Church to administer appropriate emergency treatment, to hospitalize, and/or to order injections/anesthesia/surgery for my child as named above. Furthermore, I understand I am financially responsible for charges incurred and authorize the physician to release information requested by the insurance company.

Signed: _____ **Date:** ____ / ____ / ____