MEDICAL INFORMATION AND RELEASE



This form must be completed and emailed to wmforms@mbcb.org

Participant Name	Select Event:	\square Mississippi Baptist All-State Youth Choir & Orch	estra 🗆 HeartSor	ng 🗆 Sur	mmer Music & Arts Cam	p for Kids (SMACK)
Address Pl 0 Box or Street Redical Insurance Company Pol to box or Street Redical Insurance Company Pol December 1	Participant Nar	me	Da	ate of Birth	Age	Gender
Address Pl 0 Box or Street Redical Insurance Company Pol to box or Street Redical Insurance Company Pol December 1	Grade Last Cor	npleted: Parent/Guardian Names		Church		
P O Box or Street City State Zip Code Medical Insurance Company Policy # PLEASE INCLUDE A SCAN OF BOTH SIDES OF THE INSURANCE CARD. IF YOU DO NOT HAVE MEDICAL INSURANCE, ENTER "NONE" ABOVE. EMERGENCY CONTACTS Primary Relationship Cell # Home/Nork # Alternate #1 Relationship Cell # Home/Nork # Alternate #1 Home/Nork # Alternate #1 Home/Nork # Alternate #1 Home/Nork # HEALTH HISTORY Do you currently have or have you ever been treated for any of the following? YES NO CONTON DETAILS OF CONDITION AND CURRENT TREATMENT Contacts/Glosses Legally Bind Contacts/Glosses Earlyteys/Nose/Sinus problems Barryteys/Nose/Sinus problems Head injury or Concussion Nosebleeds Fainting Spelly/Dizzlnes/POTS Secures/Epilepy Other neurological problems High Blood Pressure Adult or congenital heart disease/heart attack/chest pain (angina)/coronary artery disease/heart murriur. Any heart surgery or procedure. Explain all "yes" answers. Schoke/TIA Ashma OSTUCKIVE Sleep Apnea/Sleep Disorders Other Lung/Respiratory Problems Babetes Cellac Disease Cellac Disease Muscle or Bone Issues Muscle or Bone Issues Any other Presylvalar Attacks Depression United Tracks and Nopitalizations Any other medical conditions not covered above Lust any physical restrictions we should be familiar with Cicken Pox or Varicella Vaccine? Date of flast Vaccine: Medical Institute Care Date of flast Vaccine: Date of flast Vaccine: Date of flast Vaccine:						
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Name						Date of Birth			
ALLEI	RGIES								
Are you	u allergi	c to or do you have any adve	rse reaction to ar	ny of the foll	lowir	ng? Please explain any r	eaction and treatment.		
YES	NO	ALLERGIES / REACTIONS	ALLERGIES / REACTIONS			PLAIN			
		Medication							
		Food							
	Environmental (animal, smoke, mold, etc.)								
	Insect bites/stings								
MED	ICATIO	ONS							
List all	medicat	tions currently used, includin	g any over-the-co	ounter medi	catio	ns. If additional space i	s needed, please indicate on a separate sheet and attach.		
	VEDICA.	TIONS ARE ROUTINELY TAKE	:N						
MEDICATION		DOSE FREQUEN		CY	REASON				
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							ard (MBCB) event staff to administer first aid and over-		
							Aississippi Baptist Convention Board sponsored event,		
							or MBCB event staff to select a physician and/or hospital medication to meet any emergency medical needs. I		
				appropriate	e me	dical personnel and/or	the health insurance company if I am unable to do so. I		
		imary responsibility for any r		hin Ministri	os N	Aississinni Dantist Conv	antian Daard to participate in the activities of this event		
							ention Board to participate in the activities of this event, rsity, their officers, directors, agents, employees, propert		
			•				udgments, executions, debts, claims and demands of ever cutors or administrators have now or may hereafter have		
							ndersigned hereby declares that the terms of the herei		
release	and inf	formation disclosed have bee	en completely rea	d and are fu	ılly u	nderstood and volunta	ily accepted.		
Signatu		ent or Guardian)				Date	Daytime Phone		
NOTA	ARY A	CKNOWLEDGEMENT							
State of							{AFFIX NOTARIAL SEAL BELOW}		
County	of								
Persona	illy appea	ared before me, the undersigned	d authority in and fo	or the said cou	unty a	and state, on this			
	day	of							
						<u> </u>			
he/she	acknowle	edged that the natters contained	in the above letter	are true and	corre	ect.			
Notary I				My Co~	nmicc	ion Expires			
NOLdiy	- ubilC			iviy Con	1111155	ion expires			

DON'T FORGET TO INCLUDE INSURANCE CARD