



1009 Lytle Road  
Waynesville, OH 45068  
513.897.1009  
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## Medical Release and Indemnity Agreement Form

### Student Information:

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

### Parental/Guardian Information:

Parent/Guardian Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

### Agreement Statement:

I, the parent or guardian named above, do hereby authorize to consent for all medical and/or surgical treatment and/or other medical procedures for the above named student, which may be required in my absence. If circumstances permit, I would like to have our doctor consulter in connection with such treatment.

We fully understand that Waynesville First Baptist church carries no insurance covering injuries sustained by players participating any activity. We also fully understand the risks involving personal injury which may arise during the course of the activity, and voluntarily assume said risks and further agree on our own behalf of the student named above to release, indemnify and hold harmless Waynesville First Baptist Church, members of the Board, agents, and assignees from any all liability, claims, actions, demands and judgments arising out of any and all injuries to the student named above sustained while participating in activity at Waynesville First Baptist Church. It is further understood and agreed that Waynesville First Baptist Church, its Board, agents, and assignees do herewith disclaim any and all injuries that may occur.

### Signatures:

\_\_\_\_\_  
Parent/Guardian (Circle One) \_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian (Circle One) \_\_\_\_\_  
Date

# Additional Medical Information

**Family Physician Information:**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Insurance Information:**

Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Member Services Phone Number: \_\_\_\_\_

**Medical Information** (Please print and be thorough):

Chronic or existing Medical Conditions  
(e.g., Asthma, Seizures, Diabetes)

\_\_\_\_\_

\_\_\_\_\_

**Known Allergies:**

\_\_\_\_\_

\_\_\_\_\_

**Current Daily Medications:**

\_\_\_\_\_

\_\_\_\_\_

**Recent Shots and Vaccinations:**

Tetanus/Date: \_\_\_\_\_

Other/Date: \_\_\_\_\_