

FIRST BAPTIST CHURCH COVINGTON

16333 Hwy 1085 • Covington, Louisiana 70433 • Phone: 985-892-2149 Fax: 985-892-3090

2025 MEDICAL/PERMISSION AND LIABILITY RELEASE FORM

Name _____ Date of Birth ____/____/____ Age ____ Gender _____

Grade _____ Address _____ City _____ State _____ Zip _____

In Case of Emergency Notify: _____ Telephone _____

Family Physician _____ Telephone _____

Past Medical History

Family Insurance Company _____ Policy # _____

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Vision/Hearing Impairment	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Emotional/Behavioral Disability	<input type="checkbox"/> Chronic Asthma	<input type="checkbox"/> Appliances (retainer, contact lenses)
<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Cardiac	<input type="checkbox"/> Motion Sickness	<input type="checkbox"/> Other
<input type="checkbox"/> Mental Disability	<input type="checkbox"/> Nervous Disorder	Date of last Tetanus Shot _____

If you checked any of the above, please give details:

Allergies:

Activity Restrictions: _____

Previous Operations or Serious Illnesses: _____

Any Current Medications: (List) _____

Special Diet Needs: _____

Most recent hospitalization (reason/hospital/date): _____

Photo/Video Notice

I understand that as a participant of activities sponsored by First Baptist Church, my child may be photographed or videotaped. I understand that these photographs/videos may be used in promotional materials, publications, and video presentations of the church. I also understand that these photographs/videos may be posted on the Church websites and do hereby give my permission for such use.

Permission for Travel

I hereby give permission for my child to travel by private vehicle, rental van, or buses chartered by the First Baptist Church, Covington, LA for the time including and between the dates of **January 1, 2025** and **December 31, 2025**.

Permission for Treatment

In the event it becomes necessary, I hereby authorize any Minister of First Baptist Church, Covington, LA or a designated trip sponsor to act in my behalf with respect to the medical treatment of my child listed above for trips sponsored by First Baptist Church, Covington, LA for the time including and between the dates of **January 1, 2025** and **December 31, 2025**.

I, the undersigned, do hereby verify that the information given on this form is correct and do hereby release and forever discharge all staff, sponsors, and the First Baptist Church of Covington, LA from all claims, demands, actions, past, present, or future arising out of any damage or injury while participating in activities sponsored by the church.

Signature _____ Date: _____

Parish of St. Tammany State of Louisiana

Before me, the undersigned Notary Public in and for the Parish above stated, personally appeared _____ who executed the above permission and release form this _____ day of _____, 20__

Notary Public Notary/LA Bar Roll Number My commission expires at death/on _____

Printed Name of Notary

FBC COVINGTON MEDICATION FORM (EVENT: _____)

AUTHORIZATION for the administration of prescription Medication by FBC Covington Staff:

If a member of the FBC Covington Staff chooses to administer medications, Louisiana Law and Regulations require an authorized prescriber's (physician, dentist, advanced practice registered nurse or physician assistant) written order and parental/guardian's authorization for a nurse, director or FBC Covington staff to administer medication. Medications must be in pharmacy prepared containers and labeled with the child's name, name of drug, strength, dosage, frequency, authorized prescriber's name and date of original prescription. Over the counter medications must be in the original container and labeled with the child's name.

Name of Child: _____ Date of Birth: _____

Address: _____

Drug Name: _____ Dosage: _____

Method of Administration: _____ Times to be Administered: _____

Medication shall be Administered: From (date) _____ To (date) _____

Condition for which this medication has been prescribed: _____

RELEVANT SIDE EFFECTS TO BE OBSERVED, IF ANY: (circle) None – Rash – Drowsiness – Irritability – Loss of Appetite – Nausea – Vomiting – Diarrhea – Other _____

Management of side effects: _____

Is this a controlled drug? _____

Printed Name of Authorized Prescriber: _____

Address: _____ Tele. # _____

Authorization by parent/guardian for the administration of the above medication to childcare nurse, director or teacher:

I hereby request the above medication, ordered by the authorized prescriber for my child (name) _____ be administered by the nurse, director or FBC Covington staff. I have previously administered the above medication to my child at home. I understand that I must supply the teacher or FBC Covington staff with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. Over the counter medication shall be in the original container labeled by the parent/guardian with the child's first and last name printed on it. I understand that this medication will be destroyed if it is not picked up within one week following termination of this order.

Printed Name of Parent/Guardian: _____ Relationship: _____

Address: _____

Telephone #'s: (Home) _____ (Cell) _____ (Work) _____

Signature of Parent/Guardian: _____ Date: _____

BEFORE MEDICATION IS ADMINISTERED THE FOLLOWING MUST BE IN PLACE:

Authorization form is complete.....() Yes () No

Medication is in safety-cap container.....() Yes () No

Original prescription label is on container.....() Yes () No

Date of prescription is current (within the year for antibiotics, within expiration date for meds that are labeled).....() Yes () No

Staff Signature: _____ Date: _____