FIRST BAPTIST CHURCH

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

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 _____________________________

Family Insurance Company ____ Policy # ______________________________

Past Medical History

Medical Consent:

___Diabetes
___Emotional/Behavioral Disability
___Sleep Disturbances
___Cardiac
___Mental Disability
___Vision/Hearing Impairment
___Chronic Asthma
___Seizure Disorder
___Motion Sickness
___Nervous Disorder
___Epilepsy
___Appliances (retainer, contact lenses)
___Physical Disability
___Other
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, 2018** and **December 31, 2018**.

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, 2018** and **December 31, 2018**.

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__

____ _______________________ My commission expires at death/on ___________

Notary Public Notary/LA Bar Roll Number

____

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 – Nausuea – 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:____________________________