



**MEDICAL AND SURGICAL WAIVER/  
AUTHORIZATION FOR TREATMENT/  
RELEASE OF ALL CLAIMS**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Gender: Male Female

In the event there arises an emergency, necessitating medical and/or surgical attention, I/we hereby consent and give permission for an attending physician or hospital to administer and perform the medical care, treatment, and/or surgery deemed necessary by said attending physician of hospital and for said attending physician or hospital to make said decisions regarding medical care, treatment and/or surgery upon the above named which they, in their sole discretion, deem to be necessary and proper under the circumstances.

I/we, do hereby, for myself or my minor child, release, acquit, discharge, and forever hold harmless Heritage Baptist Church, its officers, agents, and representatives, sponsors and group members, from any and all claims, demands, causes of action, damages and liabilities for personal injury, sickness and death, as well as property damages and expenses, arising out of any accident, sickness, or illness and the treatment thereof, during said function or trip. Further, should it be necessary for the above to return home due to medical reasons, or otherwise, I/we hereby expressly assume responsibility for all transportation costs.

IN THE EVENT OF EMERGENCY, \_\_\_\_\_, (name & relation) WILL BE NOTIFIED, IF POSSIBLE, BEFORE MEDICAL ATTENTION IS ADMINISTRERED.

Emergency Contact Phone: ( ) \_\_\_\_\_ or ( ) \_\_\_\_\_

I/we understand that this MEDICAL AND SURGICAL WAIVER/ AUTHORIZATION FOR THE TREATMENT/ RELEASE OF ALL CLAIMS covers the period from April 1, 2026 through April 30, 2027.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(For minors 18 years & under, parents/guardians must sign)

**\*\*ALL AGES ARE REQUIRED TO HAVE THIS FORM SIGNED IN THE PRESENCE OF A NOTARY PUBLIC \*\***

Signature \_\_\_\_\_ Date \_\_\_\_\_

***(To be signed in the presence of Notary Public)***

\_\_\_\_\_, personally appeared before me and known by me, and in my presence executed the within and forgoing Medical and Surgical Waiver/Authorization for Treatment/ Release of All Claims form.

Witness my hand and official seal this \_\_\_\_\_ day of \_\_\_\_\_, year \_\_\_\_\_.

Notary Public \_\_\_\_\_

My commission expires: \_\_\_\_\_

*continues on back>>*

## Medical Profile

*(Note: All questions must be answered.)*

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

Doctor: \_\_\_\_\_ Office Phone: (        ) \_\_\_\_\_

Medication Allergies or other Allergies: \_\_\_\_\_

Any medical problem(s) that might need attention: \_\_\_\_\_

Medications taken: \_\_\_\_\_

Date of last Tetanus shot: \_\_\_\_\_

Do you give permission for Tylenol or a similar substance to be provided for minor ailments?

No

Yes

Health Insurance Company: \_\_\_\_\_

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

For People under 18 years old:

Full Name of Father: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Full Name Mother: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Please attach a copy of insurance card (front and back).**