

Fairway Baptist Church -- Wichita Falls, TX

Children's Ministry Registration/Medical Release Form

Child's Name _____ Birth Date _____

Home Phone _____ E-mail _____

Child's Home Address _____
Street/Apt# City Zip Code

School Child Attends _____

Church that you regularly attend and/or are a member of

Fairway Baptist Other - _____

Photographs are sometimes taken of children's ministry activities for publicity and promotional purposes, which include, but are not limited to, in-house presentations, church web sites, brochures and newsletters. Children's names or information are never used without specific permission. By signing this area, you are releasing Fairway Baptist to use photographs of your child as stated above.

Signature of Parent/Guardian _____ Date _____

Mother's Name _____ E-mail (home or work) _____

Telephone (H) _____ (W) _____ (C) _____ (Pager) _____

Address _____
 (If Different from Child) Street/Apt# City State Zip Code

Church that you regularly attend and/or are a member of (if different than child):

Fairway Baptist Other - _____

I would like to learn more about children's ministries at Fairway Yes No
I may be interested in serving in children's ministries at Fairway Yes No

Father's Name _____ E-mail (home or work) _____

Telephone (H) _____ (W) _____ (C) _____ (Pager) _____

Address _____
 (If Different from Child) Street/Apt# City State Zip Code

Church that you regularly attend and/or are a member of (if different than child):

Fairway Baptist Other - _____

I would like to learn more about children's ministries at Fairway Yes No
I may be interested in serving in children's ministries at Fairway Yes No

List other people that are authorized to pick up your child from activities sponsored by Fairway Baptist Church

Name _____ Relationship to Child _____

Address _____
 (If Different from Child) Street/Apt.# City State Zip Code

Name _____ Relationship to Child _____

Address _____
 (If Different from Child) Street/Apt.# City State Zip Code

ANNUAL UPDATES _____ | _____ | _____ | _____
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

Fairway Baptist Church -- Wichita Falls, TX
Children's Ministry Registration/Medical Release Form

Date Completed: _____

INSTRUCTIONS TO PARENTS

(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY

Child's Name: _____ Date: _____

When parents cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____

Telephone (H) _____ (W) _____ (C) _____

Address _____
Street/Apt.# City State Zip Code

2. Name _____

Telephone (H) _____ (W) _____ (C) _____

Address _____
Street/Apt.# City State Zip Code

3. Name _____

Telephone (H) _____ (W) _____ (C) _____

Address _____
Street/Apt.# City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person from Fairway Baptist Church in Wichita Falls, Texas to have your child transported to that hospital and receive treatment.

Signature of Parent/Guardian _____ Date _____

ANNUAL UPDATES _____ | _____ | _____ | _____
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

INSTRUCTIONS TO PARENT:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.

(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

Medications currently be taken by your child: _____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

(2) To prevent incidents: _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

COMMENTS: _____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

Name of Health Practitioner Date

Signature of Health Practitioner (_____) Telephone Number