

HERMITAGE HILLS

Adult Medical Release Form

*Please staple an additional page for medications if needed.

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Email address: _____

In Case of Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Doctor's Name: _____

Preferred Hospital: _____ Phone: _____

Food Allergies: _____

Medicine Allergies: _____

List of Medication and Dosage: _____

Health Insurance Provider Name: _____

Policy #: _____

Phone: _____

Should any emergency medical treatment be necessary, I, the above mentioned individual, give permission for Hermitage Hills Baptist Church, its agents, employees, volunteers, or any other representatives (together, the "Activity Sponsor") to act on my behalf and approve medical treatment. I hereby grant permission for an attending physician or hospital to administer medical care to me, if deemed necessary by Activity Sponsor. I acknowledge that participation in activities with Activity Sponsor involves risk and may result in various types of injury including, but not limited to, the following: sickness, exposure to infectious/communicable disease, bodily injury, death, emotional injury, personal injury, property damage, and financial damage. In consideration for the opportunity to participate in the activities, I acknowledge and accept the risks of injury associated with participation in and transportation to and from the activity. I accept personal financial responsibility for any injury or other loss sustained during the activities or during transportation to and from the activity, as well as for any medical treatment rendered to me that is authorized by Activity Sponsor. Further, I release and promise to indemnify, defend, and hold harmless Activity Sponsor for any injury arising directly or indirectly out of the described activity or transportation to and from the activity, whether such injury arises out of the negligence of Activity Sponsor, me, other participants, or otherwise. I understand that this medical release/permission form is valid from **September 1, 2021 through October 31, 2022**. Should any information change before that time, it is my responsibility to complete and update the permission slip.

Please sign here in the presence of a Notary. **X** _____

Notary

The above signed has personally appeared before me, and in my presence executed this within and foregoing permission and release form in the State of Tennessee, County of Davidson.

Witness my hand and official seal this _____ day of _____, 20__.

My commission expires _____.

SEAL

Notary Public _____