19290 Battery Park Road
Smithfield, VA 23430
757.356.9494

MEDICAL RELEASE FORM

NAME:_____

PARENT/GUARDIAN:_____

ADDRESS:_____

PHONE:_____ **BIRTHDAY:**_____

EVENT: All Harvest Fellowship Retreats, Camps, & Mission Trips
DATES: January 1, 2024 – December 31, 2024

Please complete the following information and supply us with a copy of student/ family insurance card:

In case of emergency, please contact_____

Day Phone:_____ **Night Phone:**_____

Insurance Company Name:_____

Policy Holder:_____

Policy Number:_____

Known Allergies:_____

Special Medication:_____

Please specify instructions:_____

_____

_____

Other needed information:

_____

_____

_____

_____

I agree to release Harvest Fellowship Baptist Church from all liability claims from any personal injury, physical and mental pain, mental disorders, property loss or property damage which may occur while on above events.

Signed:_____
Date_____

MEDICAL AUTHORIZATION FOR MINORS

I further authorize the adult counselors to treat and to authorize reasonable and necessary medical care to the above named student. This includes, but is not limited to any emergency, surgical procedure, or hospitalization if the same should become necessary wheresoever my child may be located.

This permission is given for, and in consideration of, Harvest Fellowship Baptist Mission sponsoring the trip or event and permitting my child to participate.

Signed:_____
Date_____

Notary Public Information:

State of _____ County of_____

This instrument was acknowledged before me on _____ (date) by

_____ (name of person).

Notary Public Signature_____

Commission Expiration Date_____