2023 AMERICAN BAPTIST GIRLS THRIVE RETREAT
MEDICAL FORM

NAME		TELEPHONE
STREET ADDRESS	CITY	
STATE	ZIP	DATE OF BIRTH
INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER
MEDICATIONS TAKEN REGULARLY - HOW OFTEN		
ALLERGIES - REACTIONS		
ANY HEALTH ISSUES		
LAST TETANUS SHOT	FAMILY DOCTOR	TELEPHONE
ON CAMPUS SPONSOR TO CONTACT IN CASE OF EMERGENCY	TELEPHONE	ALTERNATIVE TELEPHONE
ADDRESS		RELATIONSHIP
NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY	TELEPHONE	ALTERNATIVE TELEPHONE
ADDRESS		RELATIONSHIP

I, being a person authorized by law to give such permission, do hereby give my permission for emergency medical treatment to be given to the person who is named above. I understand that all reasonable attempts will be made to contact me as soon as possible after the condition necessitating treatment arises, and that failing to reach me, attempts to contact the alternate above will be made and that the sponsor on campus has been contacted. I understand that all reasonable precautions will be taken for safety at all times. I further release The American Baptist Women, American Baptist Churches, _______________________ (child's church), and all persons associated with these organizations from any liability associated with any accident, injury, or disease to the person that is subject to this form.

Signature of Parent/Guardian ____ Date _______________________