



first baptist friendswood

2009 MEDICAL RELEASE FORM

PLEASE PRINT CLEARLY

Participant Information:

Last Name _____ First _____
Address _____ City _____
State _____ Zip _____ Date of Birth _____ Male/Female
Home Phone _____ Cell _____
E-Mail _____

Complete the following information:

Participant Name _____

Are you covered by medical/hospitalization insurance? Yes _____ No _____

If yes, the following information is necessary:

Name of Insured _____

Insurance Company Name _____

Insurance Company Address _____

Insurance Group # _____ Policy # _____

Social Security Number of Primary Insured** _____

**Social Security Number is required to obtain medical treatment.

ATTACH COPY OF PRIMARY INSURED'S CURRENT INSURANCE CARD

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Emergency Contact _____

Relationship _____

Phone Number _____

Alternate Emergency Contact _____

Relation _____

Phone Number _____

Alternate Emergency Contact _____

Relationship _____

Phone Number _____

List any allergies, medications, special needs:
