

**Medical Release Form**  
**Bridge Street House of Prayer**

For all activities sponsored by the **Bridge Street House of Prayer**

**Date:** \_\_\_\_\_

**General Information – Please Print Legibly**

Name of Participant: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Birth Date: (m/d/y) \_\_\_\_\_ Grade \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Person to Notify: \_\_\_\_\_ Day Phone Number: \_\_\_\_\_

Evening Phone Number: \_\_\_\_\_ Cell/pager Number: \_\_\_\_\_

**Release Form**

**Minor child**

I hereby certify that I am the parent of legal guardian of the above named participant and I give my permission for him/her to take part in any of the activities sponsored by the Bridge Street House of Prayer (BSHOP). I am aware that there may be risks and dangers which I will assume personal responsibility for and will release and agree to indemnify and hold harmless BSHOP, its officers and directors, employees and any parties volunteering on behalf of BSHOP from all actions, costs, expenses or damages of any kind growing out of or related to any activities or transportation to and from activities.

*Signature of Parent or Guardian:* \_\_\_\_\_ *Date:* \_\_\_\_\_

**Adult Student (over 18) or Leader**

I hereby certify that to the best of my knowledge I am in a state of health sufficient for me to take part in any of the activities sponsored by BSHOP without jeopardizing my well-being. I am aware that when taking part in activities like this there may be risks and dangers which I will assume personal responsibility for and will release and agree to indemnify and hold harmless BSHOP, its officers and directors, employees, and any parties volunteering on behalf of BSHOP, from all actions, costs, expenses or damages of any kind growing out of or related to any activities or transportation to and from the activities.

*Signature of Participant* \_\_\_\_\_ *Date:* \_\_\_\_\_

**PLEASE FILL OUT FRONT AND BACK OF PAGE**

All information provided will be held in confidentiality.

**Medical Information**

Health Insurance Company: \_\_\_\_\_ Name of Policy holder: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Doctor's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Hospital Preference \_\_\_\_\_ Date of last Tetanus Shot (m/d/y) \_\_\_\_\_

Please list any physical limitations that might hinder participation in activities (allergies, asthma, migraines, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications**

Please list medications and doses that are taken regularly:

Med #1 _____	Dosage _____
Specific times taken each day _____	Reason for taking _____
Med #2 _____	Dosage _____
Specific times taken each day _____	Reason for taking _____
Med #3 _____	Dosage _____
Specific times taken each day _____	Reason for taking _____

**Allergies List all known**

**Describe reaction and management of the reaction**

**Medication allergies (list)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Food Allergies (list)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other allergies (list)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_