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: _____ E-mail: _____
City: _____ State:_____ Zip: _____ Phone Number: _____
Birth Date: (m/d/y) _____ Grade: ____ Person to Notify: _____
Father (or Guardian): _____ Mother: _____
Cell Number: _____ Cell Number: _____
Work Number: _____ Work Number: _____
Email:_____ Email:_____

Release Form
Minor child

I hereby certify that I am the parent or 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. My signature below authorizes the BSHOP to photograph my child for use in BSHOP publications and/or future promotional materials.

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. My signature below authorizes the BSHOP to take my photograph for use in BSHOP publications and/or future promotional materials.

Signature of Participant _____*Date:*_____

PLEASE FILL OUT FRONT AND BACK OF PAGE

BSHOP
bridge street house of prayer

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 _____
BSHOP employees are not permitted to administer any oral medication. Please plan accordingly.

Allergies List all known **Describe reaction and management of the reaction**

Medication allergies (list)

_____ _____
_____ _____
_____ _____

Food Allergies (list)

_____ _____
_____ _____
_____ _____

Other allergies (list)

_____ _____
_____ _____
_____ _____

I hereby certify that this information is correct to the best of my knowledge:
Signature of Parent, Guardian or Participant _____ *Date:* _____