



Trinity Baptist Church Student Ministry
2021-2022
Universal Release Form

Effective Dates: June 1, 2021 – August 31, 2022

Student Information:

Full Name: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_ / \_\_ / \_\_ Male/Female
Nickname: \_\_\_\_\_ School: \_\_\_\_\_
Primary Address: \_\_\_\_\_
Students Home Phone \_\_\_\_\_ Student Cell Phone \_\_\_\_\_
Student Email: \_\_\_\_\_

Parent/Guardian Information

Name: \_\_\_\_\_ Name: \_\_\_\_\_
Primary Contact: \_\_\_\_\_ Primary Contact: \_\_\_\_\_

Emergency Contact if Parents/Guardians cannot be reached:

Name: \_\_\_\_\_ Name: \_\_\_\_\_
Primary Contact: \_\_\_\_\_ Primary Contact: \_\_\_\_\_

Medical Information

Any Previous Medical History that Trinity should be aware of:

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

Any Allergies:

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

Current Medication:

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

Student: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/ Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Insurance Information:

Medical Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_
Policy/Group ID #: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

\*Required: Please attach a copy of student's medical insurance Card\*

**Statement of Release**

I, the undersigned **parent(s) or guardian(s)** of \_\_\_\_\_, **who is a minor**, do hereby authorize that Student Ministry Workers of the **Trinity Baptist Church**, should it be necessary for my child to have medical treatment while participating in a Student Ministry activity, I hereby give the person(s) in charge permission to act on my behalf to SECURE HOSPITALIZATION or medical services deemed necessary and appropriate by the physician.

I, further, release **Trinity Baptist Church** or any of its paid staff or volunteers responsibility for any accident that may occur on the way to, from, or during an event. I release Trinity Baptist Church from all claims made and liabilities assessed against them as a result of any event or activity. I release Trinity Baptist Church and all medical providers from liability in acting on my behalf in this regard and rendering such medical treatment. I assume the risk and financial responsibility for any injury resulting from any event or activity.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Guardian)

*The foregoing instrument was acknowledged before me this day  
of \_\_\_\_\_, \_\_\_\_\_ by \_\_\_\_\_  
who is personally known to me or has produced identification and who did take an oath.*

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**NOTARY PUBLIC**