

**Activity Participation Agreement For All/Any Activities
First Baptist Church of Winter Park**

PARTICIPANT'S NAME: _____ DATE OF BIRTH: _____
(LAST NAME) (FIRST NAME)

ADDRESS: _____ CITY: _____ STATE: FL ZIP: _____

PHONE: (_____) _____ PARTICIPANT'S SOCIAL SECURITY #: _____ - _____ - _____

IN CASE OF EMERGENCY NOTIFY: _____

DAYTIME TELEPHONE: _____ EVENING TELEPHONE: _____

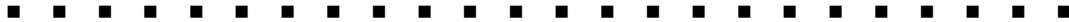
IS PARTICIPANT COVERED BY PERSONAL/FAMILY MEDICAL INSURANCE? YES NO *MEDICAL HISTORY-Reverse Side

FAMILY PHYSICIAN: _____ PHONE: (_____) _____

FAMILY INSURANCE: _____ PHONE: (_____) _____

GROUP AND/OR POLICY NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____



PARTICIPATION AGREEMENT AND PERMISSION FOR TREATMENT AUTHORIZATION

By signing below, the participant (or parent/guardian if participant is a minor) acknowledges and accepts the risks of physical injury associated with participation in church sponsored activities on or off church property. My permission is granted for First Baptist Church of Winter Park, FL staff member(s) or activity sponsor(s) in charge of any/all activities for year _____ to obtain necessary medical attention in case of sickness or injury for _____ (Participant).

I/We the undersigned, do hereby release, and forever discharge all sponsors and First Baptist Church of Winter Park from any and all claims, demands, actions or cause of action, past, present, or future arising out of any damage or injury while participating in these activities on or off church property. The participant (or parent/guardian if participant is a minor) accepts personal financial responsibility for any bodily or personal injury sustained while participating in church sponsored activities on or off church property.

If a dispute over this agreement or any claim for damages arises, the participant (or parent/guardian) agrees to resolve the matter through a mutually acceptable arbitration process.

Birth day of Parent/Guardian: _____ Social Security # of Parent/Guardian: _____ - _____ - _____

STATE OF FLORIDA COUNTY OF _____

The PARTICIPATION AGREEMENT AND PERMISSION FOR TREATMENT AUTHORIZATION was acknowledged before me

this _____ day of _____, _____, by _____
(Month) (Year) (Signature of participant/guardian if participant is a minor)

(Notary Signature)

Personally Known _____ OR Produced Identification _____ Type of Identification Produced: Drivers License Passport State/Federal ID Card

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PAST MEDICAL HISTORY
(CHECK, GIVING APPORPRIATE INFORMATION)

Asthma: _____ Sinusitis: _____ Bronchitis: _____ Kidney Trouble: _____ Heart Trouble: _____

Diabetes: _____ Dizziness: _____ Stomach Upset: _____ Hay Fever: _____ Other: _____

Allergies: Food: _____ Insect Stings/Bites _____

Penicillin or other drugs (name): _____

Poison, sumac, oak, or ivy: _____

Any current medications (list): _____

Special Diet (name): _____

Childhood Diseases: Chickenpox _____ Measles _____ Mumps _____ Whooping Cough _____

Other: _____

Date of last TETANUS shot: _____