

**COLLEGE EMERGENCY MEDICAL FORM**  
**Shiloh Terrace Baptist Church**  
**9810 La Prada**  
**Dallas, Texas 75228**  
**972-857-9707**

**Both** sides of this form must be completed on all participants or their parents and **notarized** by a certified Notary Public. There is a Notary located at the church. Please call for an appointment.

Participant's Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Participant's Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Phone: Home \_\_\_\_\_ Cell Phone \_\_\_\_\_

Physician Name \_\_\_\_\_ Physician Phone Number \_\_\_\_\_

Please list any medication you are taking and/or any medical condition that we need to be aware of:

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

Allergies:

Food Yes \_\_\_\_\_ No \_\_\_\_\_ Specify \_\_\_\_\_

Medicines Yes \_\_\_\_\_ No \_\_\_\_\_ Specify \_\_\_\_\_

Insects Yes \_\_\_\_\_ No \_\_\_\_\_ Specify \_\_\_\_\_

Other Yes \_\_\_\_\_ No \_\_\_\_\_ Specify \_\_\_\_\_

Shots up-to-date? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last Tetanus shot: \_\_\_\_\_

**Please sign below with a Notary present to witness your signature.**

\_\_\_\_\_ Has my permission to participate in church activities and to travel by transportation provided by the church or workers/counselors. I authorize the adult in charge to authorized medical treatment when I cannot be contacted. I understand every effort will be made to contact me before such action is taken. I assume financial responsibility for emergency care. I agree not to hold the church or workers/counselors financially liable for any incident relating to the activity/trip.

**I give my permission for Shiloh Terrace Baptist Church to use my photograph or video for promotional materials and website. Yes \_\_\_\_\_ No \_\_\_\_\_**

Signature of Participant or Parent (parent if under 21) \_\_\_\_\_ Date \_\_\_\_\_

"Given under my hand and seal of office, this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_."

Notary Public in and for the State of Texas \_\_\_\_\_

**(Please complete information on the other side.)**

## Insurance Information

This information will be requested by the physician and medical facility in the event of an emergency. Please help us by making sure you give complete and correct information.

Participant/Parent/Guardian Name (as listed in your company records) \_\_\_\_\_

Participant/Parent/Guardian Occupation \_\_\_\_\_

Company Name \_\_\_\_\_

Company Address \_\_\_\_\_

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

Insurance Company Name \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

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

Insurance Company Phone \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Policy carried under what name \_\_\_\_\_

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Emergency Name (**OTHER THAN YOURSELF OR PARENT**): \_\_\_\_\_  
(The parent or guardian will be contacted first, in case of an emergency.)

Relationship: \_\_\_\_\_

Emergency Phone #: Home \_\_\_\_\_ Work \_\_\_\_\_

Cell \_\_\_\_\_

**This Medical Form is valid one year to date of Notary signature and is valid for all Shiloh Terrace Baptist Church sponsored activities. If any of the information you have provided should change before this date, please complete a new form and return it to the church office.**