

**KARL ROAD BAPTIST CHURCH**  
**5750 KARL ROAD, COLUMBUS, OH 43229**  
**(614) 885-3929**

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Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Check One:       Mid-High       High School       College       Staff/Parent

Under 18?    Yes       No

If Yes Name of Parent/Guardian: \_\_\_\_\_

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

Home Phone# \_\_\_\_\_ Work Phone# \_\_\_\_\_

Person to contact in case of emergency: (Not Parent/Guardian)

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

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

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**CURRENT MEDICAL INFORMATION:**

Allergies (including food): \_\_\_\_\_

Illnesses/Injuries: \_\_\_\_\_

Special Physical Concerns: \_\_\_\_\_

Medications: \_\_\_\_\_

**In case parent/guardian or emergency contact cannot be notified immediately do you authorize a leader to administer any of the following:**

Tylenol       Aspirin       Ibuprofen       Pepto-Bismol

Name of Health Insurance Company: \_\_\_\_\_

Name of Person Insured: \_\_\_\_\_ S.S. # \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Co Phone # \_\_\_\_\_

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

**IT IS HELPFUL TO PROVIDE A PHOTOCOPY OF YOUR INSURANCE CARD.**

**PARTICIPATION AGREEMENT:**

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 the activity described above. Except for gross negligence on the part of the church, the participant (or parent/guardian) accepts personal financial responsibility for any bodily or personal injury or illness sustained during the activity. Further, the participant (or parent/guardian) promises to hold harmless the church and all of its representatives for any injury/illness related to the activity.

I further authorize the church or their representative, employee, or agent to obtain any medical treatment for the participant that should appear to be necessary during the activity, and I will be responsible for the full payment of expenses relating to such illness or injury.

I affirm that I have the right to authorize and agree to the foregoing. I have carefully read and understand this agreement, and have willingly paced my signature below as evidence of my acceptance of all the conditions contained herein.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_