

**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 activity. My permission is granted for a First Baptist Church Winter Park staff member or activity sponsor 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 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 events. Except for gross negligence on the part of the sponsor, the participant (or parent/guardian if participant is a minor) accepts personal financial responsibility for any bodily or personal injury sustained during the activity.

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.

Birthdate 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)

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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: \_\_\_\_\_