Medical Release Form/Permission to Treat *2009*

Name:_______________________________ Social Security#:____________________

Birthdate:____/____/______ Age:____ Sex (M/F):_____

Address:____

City:__________________________ State:_______ Zip:_____________

Parent/Guardian:____

Home Phone:(___)________________Work Phone:(___)_________________________

Secondary contact to notify in event of emergency:______________________________

Their relationship to you:__________________ Their phone:(___)_________________

Please supply ALL of the following information. Attach a copy of your insurance card.

Medical Insurance Co.:___________________ Group#________ Policy#:___________
Company's address:_____________________ Company's Phone:(___)_____________
City:_________________________ State:________ Zip:______________

Family Physician's Name:________________________ Phone:(___)______________

Physical Limitations (Asthma, diabetes, allergies, etc.), and/or special instructions (Allergic to certain meds, rare blood type, wears contact lenses, etc.):

List ALL medication taken on a regular basis and/or any brought with you to the event (Prescription meds MUST have a pharmacy label and name of doctor):

List all operations/serious injuries and dates within the past five (5) years:

The Health History is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted.

Emergency Authorization - I hereby give permission to medical personnel selected by the participant's Church sponsor/his designee or conference staff to order X-rays, routine tests, and treatment for myself. In the event of an emergency and neither my primary contact nor

secondary can be reached, I hereby give permission to the physician selected by the Authorized Agent to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery to myself as named above. I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company. In addition, I have, and do hereby, release the church, its employees or agents from liability associated with participation in a church activity. I understand that if I do not have medical insurance, I, as the parent or guardian, will be responsible for any medical expenses in the event of a sickness and/or injury. I understand that there are risks involved in taking place in recreation activities and other activities related to participation in youth functions.

___________________________________ ____/_____/_____
Signature of Parent/Guardian Date

The following to be completed by the notary witnessing parent/guardian's signature.

The State of _________________________ the County of________________________
Before me, a Notary Public, on this day personally appeared ____________________
known to me (or proved to me on the oath of__________________________________) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration therein expressed. Given under my hand and the seal of the office this ________day of ___________________, year:______________.

____
Notary Public, Signature

My commission expires the _________ day of______________, Year:______________.