

# Medical Release Form

This form must be signed and notarized.

Name of Church: \_\_\_\_\_ City/State: \_\_\_\_\_

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 (Prescription meds MUST have pharmacy label and doctor's name:

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

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

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

Date of last Tetanus Shot: \_\_\_\_\_

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 camp staff to order X-rays, routine tests, and treatment for my child. In the event of an emergency and neither the secondary contact nor myself can be reached, I hereby give permission to the physician selected by the participant's Church sponsor/his designee or camp staff to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery for my child 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 below named event, its directors, employees, or agents from liability associated with participation in the below named event.

\_\_\_\_\_  
Name of Event

\_\_\_\_\_  
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 \_\_\_\_\_, A.D. \_\_\_\_\_.

\_\_\_\_\_  
Notary Public, State of \_\_\_\_\_

\_\_\_\_\_  
Print name of Notary Public here

My commission expires the \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_.