

Adult Medical Information 2019-2020 **ALLERGIES:** \_\_\_\_\_

Adult/Leader Information:

Name \_\_\_\_\_ MALE  FEMALE

Home address \_\_\_\_\_ City, St, Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_\_

Email address \_\_\_\_\_

Emergency Contact:

Name \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Medical Information:

Doctor Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name and reason for all medication taken regularly \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Health Problems or Chronic Conditions \_\_\_\_\_

\_\_\_\_\_

Last Tetanus Shot \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Plan: PPO  HMO  OTHER

Member ID/Policy# \_\_\_\_\_ Verification Phone # \_\_\_\_\_

Effective immediately, I assume all risk and hazards and do hereby release and agree to hold harmless St. Peter's United Methodist Church (the church) and its servants, volunteers, agents, and employees from all liability for personal injury or property damage for all actions taken in good faith during the church activities. In the event I cannot be reached or cannot communicate in an emergency, I hereby give my permission to the physician, hospital, or medical service selected by the leaders of the church to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child or myself as named above. It is understood that a conscientious effort will be made to communicate with me or the emergency contact listed before any action is taken. I accept responsibility for any and all expenses incurred from medical treatments provided. I have read this release and understand its terms and execute it voluntarily and with full knowledge of its significance.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_