First United Methodist Church Youth Medical Information and Release Form

Name of Participant/Volunteer _____
(please print)

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

If a minor, mother's (or legal guardian) name _____

Home Phone _____ Cell Phone _____

If a minor, father's (or legal guardian) name _____

Home Phone _____ Cell Phone _____

Other Emergency Contact Name _____

Phone _____ Relationship _____

Family Doctor _____ Phone _____

Family Dentist _____ Phone _____

Health Insurance Company _____

Group Number _____ Policy Number _____ Phone _____

PERSONAL MEDICAL INFORMATION

Known Allergies _____

Other Medical History _____

Current Medications _____

Dietary Restrictions _____

Physical Restrictions _____

In the event that I am unable to be reached at the phone numbers above, I hereby authorize emergency medical treatment, surgery, or dental care to be given to the above participant as considered advisable or necessary in the judgement of an emergency medical professional or attending physician.

_____ _____
signature (parent or legal guardian if under 18) Date