Greenville Church of the Brethren

Adult (Age 18 And Over) Medical Form

(Annual Consent)

MEDICAL CONSENT & RELEASE FORM

In case of emergency, I hereby give permission to the physician and/or the hospital selected by the trip/activity leader to hospitalize, secure treatment for, and to order injection, anesthesia or surgery for myself, as named above.

If I need medical services which require my consent, and my emergency contact person cannot be reached, staff members or other youth advisors of Greenville Church of the Brethren have my consent to take me to a properly licensed, practicing physician/hospital or to call the EMS. I accept financial responsibility for medical services provided to me. Further, I release Greenville Church of the Brethren and its staff/advisors from any liability in such situations.

Date signed: _____

Name:_____(please print)

Authorization:_____(signature)

Address: _____

(_____) _____ - _____ (_____) _____ - _____

Phone number: Alternate phone number (ie: cell phone)

IN CASE OF EMERGENCY:

We make every effort to provide a safe and secure environment for you during our events. In order to better protect the safety and health of yourself, we request that you provide the following information:

In case of an emergency, we will contact the following emergency contact listed below. We request that the person listed below is authorized to act on your behalf.

Emergency Contact:

Name: _____

Address: _____

Phone Number: _____

Relationship to Adult: _____

I will provide to the church office new or updated changes pertaining to any of the information that I have provided on this form.

(This form must be completed on both sides for persons over 18 years of age)

MEDICAL INFORMATION FORM

Do you have any health conditions, allergies or diet/mental/physical restrictions?

_____YES _____NO
EXPLANATION:

Please list any medications that you are currently on:

_____

_____

Do you have any <u>medication</u> allergies or other allergies?

_____YES _____NO

Please list allergies:

_____

_____

If the need arises, please give me:

Aspirin_____ Tylenol_____ Ibuprofen_____ Nothing_____

Date of Birth: _____ Date of last Tetanus Shot: _____

Health Insurance Co:_____ Policy #_____
Phone: (_____) _____ - _____

Physician Name: _____

Physician Phone Number: (_____) _____ - _____

Physician Address:_____

Preferred Hospital: _____

Preferred Hospital Address: _____

Dentist Name: _____

Dentist Phone: (_____) _____ - _____ Address: _____

(This form must be completed on both sides for persons <u>over</u> 18 years of age)