GENERAL & MEDICAL RELEASE FORM

NAME:_____ EVENT:_____

SSN:_____

BIRTHDATE:_____/_____/_____ AGE:_____ SEX:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP: _____

PARENT/GUARDIAN:_____

HOME PHONE:_____ WORK:_____ CELL:_____

SECONDARY CONTACT TO NOTIFY IN CASE 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_____

CITY:_____ STATE:_____ ZIP:_____

COMPANY'S PHONE:_____

FAMILY PHYSICIAN'S NAME:_____

PHONE:_____

PHYSICAL LIMITATIONS (asthma, diabetes, allergies, etc.) AND/OR SPECIAL INSTRUCTIONS (allergic to certain meds or foods, rare blood type, wears contact lens, etc):

_____

LIST **ALL** MEDICATION TAKEN ON A REGULAR BASIS AND/OR ANY BROUGHT WITH YOU TO THIS 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 CAMP STAFF TO ORDER X-RAYS, ROUTINE TESTS, AND TREATMENT FOR MY DEPENDANT. 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 MY DEPENDANT 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 RAINBOW PRESBYTERIAN CHURCH AND ITS EMPLOYEES, AGENTS, OR REPRESENTATIVES FROM LIABILITY ASSOCIATED WITH PARTICIPATION IN SAID ACTIVITY.

I UNDERSTAND THAT IF I DO NOT HAVE MEDICAL INSURANCE, I, AS 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 PART 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 _____, A.D. _____.

Notary Public, State of

_____

_____

Print name of Notary Public here

My commission expires the _____ day of _____, A.D. _____.