Adult Medical Release Form 2024

FBC Paris

Name: _____ Shirt Size: _____

Gender: Male Female Birth date: _____ Age: _____

Email: _____ Cell phone: _____

Home address: _____

City _____ Zip: _____

Emergency contact name: _____

Relationship to sponsor: _____

Email: _____ Cell phone _____

Home address: _____

City _____ Zip: _____

If the above is unavailable during emergency, contact: _____

Relationship to sponsor: _____

Email: _____ Cell phone _____

Home address: _____

City _____ Zip: _____

Do you have any of the following allergies?

Latex	Yes	No	Penicillin	Yes	No
Insect Stings	Yes	No	Ivy Poisoning	Yes	No
Other Drugs	Yes	No	Other Nonfood Allergies: _____		

Please list any food allergies (peanuts, milk etc.)

_____

Do you have any medical or health problems/conditions, and or have you any type of chronic or recurring illnesses: Yes No

If yes, please describe: _____

_____

_____

_____

Name of family physician: _____
Phone number: _____
Are you currently taking medication Yes No If so, please state the medication

_____

_____

_____

If so, will you be bringing the medication to the activity? Yes No
If yes, please indicate the dosage prescribed, and the reason for the medication.

_____

_____

_____

Date of last tetanus shot: _____
Is there medical or hospitalization insurance which provides benefits to you? Yes No
If yes, please complete:
Name of Insurance Company: _____
Address: _____
Phone Number: _____
Policy Holder's Full Name: _____
Policy Number: _____ Group Number: _____

I understand that, in the event I require medical or dental treatment while engaged in the activates – either on or off campus at First Baptist Paris – reasonable efforts will be made to reach the emergency contact. However, if I am not able to verbally give my consent and the emergency contact cannot be reached, I hereby consent and give permission to the ministry's sponsor, acting on behalf of the ministry with respect to the activity, as agent for me, to consent to any medical treatment deemed medically necessary, including but "not" limited to: x-ray examination; injection; anesthesia; medical, dental or surgical diagnosis and treatment; and hospital care and treatment advised and given by a licensed physician, surgeon, dentist, or registered nurse, either as an outpatient or in a hospital. I further agree to indemnify and hold harmless any medical professional or church leader from loss, claim, or liability who provides authorization, medical, or first aid treatment to myself as deemed appropriate. To the best of medical problems/conditions and pertinent information for myself indicated on this medical consent form.

Signature_____

Print Full Name: _____ Date: _____