Medical Release Form

(One form per participant and please complete in pen)

Legal Name: _____ Birthdate: ___/___/_____ Gender: _____
Home Address: _____
Home Phone: _____ Cell phone: _____
Email: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Relationship to participant: _____

MEDICAL INFORMATION:

Primary Physician: _____ Phone #: _____
Insurance Company: _____ Policy #: _____
Name of person insurance is under: _____ Group #: _____
Blood Type_____ (if known)

HEALTH HISTORY:

Do you have any physical limitations that would hinder your ability to participate in vigorous activities? If so, please explain.

_____

Do you have any medical problems? If so, please explain.

_____

Are you allergic to any medications or food? If so, please explain.

_____

Describe your present physical fitness (e.g. for walking, manual labor, heavy lifting, carrying luggage).

_____

Do you take any medication on a regular basis? If so, please list:

_____

CONSENT FOR EMERGENCY TREATMENT **(Signature required from participant, or parent or guardian if under 18)**

Note: If you should require medical attention while on an activity with Daniell Baptist Association (or one of its partners) for injuries received or illness contracted prior to coming, please provide trip coordinators with information necessary to give proper medical service during the trip.

In case of an emergency, I hereby give permission to the physician selected by the church/group sponsor representative to hospitalize, secure proper treatment for and order injections, anesthesia, or surgery for myself/my child (ward) as named above. I also hereby give permission for my child to participate in all activities, travel, service projects, and other activities.

I, therefore, agree to assume as an explicit condition of my/my child's (ward's) participation, any and all risks, including, but not limited to these enumerated above. I agree to hold harmless the above named sponsor, the sponsoring church or group from any and all liabilities, claims, demands, and causes of action whatsoever which may arise due to the participation of myself or my child (ward). I realize, also, that in the event of illness or injury while participating in its activities, medical treatment may be required. I hereby give permission for any such treatment to be rendered, and I agree to bear the cost of such treatment.

Participant (or Parent/Guardian) Signature: _____ Date: _____

_____ Date _____
Notary Public Stamp