United Methodist Youth Fellowship

MEDICAL INFORMATION: Adult

Date Received: _____________

Expiration Date: ____________

Adult Participant's Full Name: _______________
Social Security Number: _____________
Address: _________________
City / Zip: _________________

Date of Birth: _______________________
Age: ____
Home Phone: ____________________
E-mail:

Name of School: ____________________

Grade: ________

Spouse's name: _________________
Occupation: ___________________

Home Phone: ____________________
Work Phone: ___________________
Cell Phone: ____________________

Person to contact if spouse is unavailable:
Name & relation: ____________________
Occupation: _______________________

Home Phone: ____________________
Work Phone: ____________________
Cell Phone: ______________________

Physician's Name: _____________________

Phone: ____________________

Please list any recurring health problems: (i.e. stomach aches, ear infections):
____

Are immunizations up to date? _______

If no, please explain ______________________

Date of last Tetanus Shot: ____________

Any activity limitations? __________________

Do you wear contacts? ______

Any specific activities to be encouraged? __________________
Any specific activities to be restricted? _____________________
List any medications or drugs taken regularly: ________________
Any special medical or dietary regime to be continued? ____________

MEDICAL RELEASE & INSURANCE INFORMATION
Valid December 28, 2008 to December 28, 2009

Name of Insured: ________________________

Insurance issued in the name of: _____________________________

Medical/Health Insurance Co. Name: _____________________

Subscriber ID: ___________________ **Group Number:** _____________________

Preauthorization Phone # _____________________________________

In the event I/We become ill, injured, or for any reason requires medical treatment while attending a United Methodist Youth Fellowship function or activity, I do hereby consent to any and all medical or surgical treatment, including anesthesia and operations, which may be deemed advisable by any qualified physician selected by agents or officials of the Columbiana United Methodist Church, Columbiana, AL. In the event treatment is called for which a physician or other health care provider refuses to administer without my/our consent, I/we hereby authorize the Staff at Columbiana United Methodist Church, Columbiana, AL. or any other representatives of Columbiana United Methodist Church, Columbiana, AL. to give such consent and further agree to hold any person harmless from any claims, demands, or suits of any nature arising from the giving of such consent so long as the treatment is administered by or under the supervision of a licensed physician. I further authorize the release of the listed medical information to appropriate medical personnel and/or the health coverage insurance company. I will notify the church if I feel there are any health considerations that would prevent my participation in any activity. I also give my permission for leaders to restrict me from participation in any activities that they have any questions about for health or other reasons.

The intention of this release is to grant authority to administer and perform any and all examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the course of the patient's care, be deemed advisable or necessary by any qualified physician. I will see that payment is made for all medical expenses incurred for medical treatment for the above named person. This payment will be made by myself or by my insurance company providing coverage for the above-named person.

I the undersigned, certify that the person named above, has my express permission to participate in all activities, of any nature, sponsored by Columbiana United Methodist Church, Columbiana, AL. from the date received. I fully release Columbiana United Methodist Church, Columbiana, AL., its authorized representatives and staff from all liability of any kind and character upon any claim, demand, or cause of action that might be asserted in our behalf against said church, representatives or staff.

I _________________________________ understand and agree to abide with the restrictions placed on my activities by CUMC.

Signature of Participating Adult: ______________________________________ Date _______________

Sworn to and subscribed before this _________ day of ________________________ .

NOTARY PUBLIC
State of Alabama, My commission expires:

____

PRINT, TYPE OR STAMP
COMMISSIONED NAME OF NOTARY PUBLIC

Personally known_______ or __________________________Produced Identification (list type)

Please include a copy of your insurance card, front and back, with this Medical Information Form.