Medical Release Form

Name _____ Sex _____ Grade (if applicable) _____

Address _____

City/ State _____ _____ Zip _____

Birth date_____ Age _____ Phone #'s (home/cell) _____

Complete this box if this form is for a minor:

Parent (s) Name _____

Phone #s Home, Work or Cell:_____

Responsible Party's Insurance Company _____

Policy Number _____Insurance Phone _____

Emergency Contact _____

Phone Number _____ Relationship _____

Medical Information:

1. Are you currently under a doctor's care? _____ If so, for what reason? _____

2. Have you had any serious physical or emotional illness in the past 2 years? _____

If so, please explain. _____

3. When was your last physical exam? _____

By whom? _____

4. List medications taken regularly & give reasons. _____
(use back if needed)

5. List allergies (foods, medications, others) _____

_____

6. Do you have any physical limitations? _____

7. Date of last tetanus shot. _____

(Turn page over to complete)

To whom it may concern: The undersigned does hereby agree/give permission for our myself/my child _____, to attend and participate in activities sponsored by Fellowship Evangelical Free Church. We (I) authorize an adult to consent to an X-ray, examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. We (I) understand that this form releases Fellowship Evangelical Free Church, it's staff, and volunteer leaders/chaperones of any liability against personal losses of named individual. We (I) also agree to provide return home transportation at my own expense should we (I) become ill or if deemed necessary by the staff.

Adult Participant Signature _____ Date _____

Parent/guardian Signature _____ Date _____
(if minor)