CONFIDENTIAL

2016-2017 FUMC Youth Chaperone MEDICAL INFORMATION

Adult's Full Name: _____ Date of Birth _____ Age _____

Address: _____ Home Phone: _____ Female ◯

City / Zip: _____ Cell Phone: _____ Male ◯

Occupation: _____

Email: _____ Work Phone: _____

Person to contact in case of emergency

Name: _____ Home Phone: _____

Relation: _____ Work Phone: _____

Occupation: _____ Cell Phone: _____

Physicians Name: _____ Phone: _____

HEALTH HISTORY (check all those that apply)

ILLNESSES:		**DISEASES:**		**ALLERGIES:**		**SUBJECT TO:**	
Frequent ear infections	☐	Chicken pox	☐	Penicillin	☐	Sleep Walking	☐
Frequent Colds / Sore Throats	☐	Measles	☐	Aspirin	☐	Fainting	☐
Sinusitis / Bronchitis	☐	Mumps	☐	Other	☐	Bedwetting	☐
Strep Throat	☐	German Measles	☐			Constipation	☐
Mononucleosis	☐	Whooping Cough	☐	Food	☐	Other	☐
Heart Defect / Disease	☐	Tuberculosis	☐	Insect Stings	☐		
Epilepsy / Convulsions	☐	Polio	☐	Poison Ivy/Oak/Sumac	☐		
Bleeding / Clotting Disorders	☐	Diabetes	☐	Hay Fever, etc.	☐		
Hypertension	☐	Asthma	☐				
Stomach Problems	☐	Arthritis	☐				

Other Diseases or Details of Above:

Are immunizations up to date? Yes

If no, please explain

Date of last Tetanus Shot

Date of last TB skin test

Any activity limitations?

Do you wear contacts? Yes

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
Valid June 1, 2016 to August 31, 2017

Name of Adult Counselor _____
Insurance issued in the name of_____
Medical/Health Insurance Co. Name: _____
Policy Number: _____ Group Number: _____
Preauthorization Phone # _____

I certify that in the event I become ill, injured, or for any reason require medical care or attention while attending a First United Methodist Church function or activity, I do hereby consent to any and all medical or surgical treatment, including anesthesia and operations ("Medical Treatment"), which may be deemed advisable or necessary by any qualified physician selected by agents or officials ("Staff") of the First United Methodist Church to further the health, healing, reparation, and/or physical and mental welfare of myself. In the event treatment is required which a physician or other health care provider refuses to administer without my consent, I hereby authorize the Staff at First United Methodist Church or any other representatives of First United Methodist Church ("Staff"), to give such consent and I further agree to hold any person harmless from any claims, demands, or suits of any nature arising from providing such consent, so long as the Medical Treatment is authorized only for care 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 companies. I will notify the Staff if I believe or have knowledge that there are any health considerations that would prevent my participation in any activity.

The intention of this release is to grant authority to the Staff to consent to the administration and performance of any and all examinations, treatments, anesthetics, operations, diagnostic procedures, and/or other Medical Treatment which may now or during the course of the patient's care, be deemed advisable or necessary by any qualified physician. I accept responsibility as guarantor for payment of all medical expenses incurred for medical treatment for myself, even though the parties to this Release may believe that some or all of the expenses may be the responsibility of one or more insurance companies. This payment will be made by me or by my insurance company providing coverage for the above-named youth.

I the undersigned, certify that I can participate in all activities, of any nature, sponsored by First United Methodist Church for the 2016-2017 school calendar year. I fully release First United Methodist Church, its authorized representatives and staff from any and all liability of any kind and character upon any claim, demand, or cause of action that might be asserted in my behalf against said church, representatives or staff.

Signature of Participant: _____ 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