**PLEASE ATTACH A COPY OF YOUR CURRENT INSURANCE CARD (FRONT & BACK) TO THIS FORM**

# ADULT MEDICAL RELEASE

## FIRST BAPTIST CHURCH OF ELLISVILLE

Name ______________________________ D.O.B. ________ Age _____ Sex ____

Address ______________________________ City ______________________

State ______________________ Zip Code ______________________

Person to Contact in case of emergency ______________________________

Phone ______________________

Insurance Company ______________________ Phone ________________

Insurance Company Address ______________________________

Insurance Policy Number ______________________________

Physician's Name ______________________ Phone ____________

Please list any allergies ______________________________

______________________________________________________

Please list medications that you are allergic to ______________________

Please list any and all medications that you are now taking ____________

______________________________________________________

Date of last tetanus shot ______________ Blood Type ____________

Please list any past injuries or surgeries ______________________________

______________________________________________________

In the event I am rendered incapable of making a decision concerning my medical welfare, I do give permission to First Baptist Church of Ellisville leaders to select a physician and to authorize x-rays, routine tests, injections, surgeries, anesthesia and treatment deemed necessary. This authorization is for the dates of January 1, 2010 through December 31, 2010.

____________
Date

______________________________
Signature

______________________________
Notary
Notary Public-State of Missouri
County of St. Louis
My commission expires __________