Allergies:____________________

Kirkwood United Methodist Church
201 West Adams
Kirkwood, Missouri 63122
314-966-8167

ADULT VOLUNTEER MEDICAL RELEASE FORM

I ____________________________________, authorize another adult representing Kirkwood United Methodist Church on this trip to consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment and/or hospital care rendered to me under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine by the state in which they practice, during the duration of the trip identified below:

Activity: ____ALL KUMY/Confirmation Activities Dates: _____All______________.

Birth Date:___________________________ Social Security #: ____________________

Address: ____

City/State/Zip Code: ____

Home Phone #: ___________________Work/Cell Phone #: ______________________

Medical/Hospitalization Plan/Form: ____

Medical/Insurance ID #: ____

Medical/Insurance Group #: ____

Car Insurance and drivers license on file: ☐ Yes ☐ No

Emergency Contact: _____________________________ Relationship: ___________

Home Phone #: ___________________Work/Cell Phone #: ______________________

____ ____________________

Participant's Signature Date

Date(s) of Safe Sanctuary Training

_____________________________ _____________________________

Kirkwood United Methodist Church Camping and Retreat/Conference

Health Statement: Please fill this out in order that we might be more fully aware of your youth's special needs and facilitate any medical attention that might be required while on an event/trip.

Name of Youth:					
Parent Name(s)			Phone #:		
Address (if different from home)					
Physician's Name:			Phone #:		
Dentist's Name			Phone #:		
Allergies (Food and Medicine):					
Restrictions on Activities:	□ None	□ Sports	□ Swimming	□ Hiking	□ Other
Restrictions on Diet:					
What over-the-counter medications may we give to your youth at an event/trip? (ex. Advil)					
Required Medications:					
Allergies:	□ Penicillin	□ Sulfa	□ Tetanus Shot	□ Other	
	□ Poison Ivy/Oak		□ Hay fever	□ Bee or other insect sting	
SUBJECT TO:	□ Fainting	□ Convulsions	□ Headaches	□ Earaches	□ Cramps
	□ Toothaches	□ Swimmer's Ear	□ Sore Throat	□ Homesickness	□ Exhaustion
	□ Sleep Walk	□ Nose Bleeds	□ Bed Wetting	□ Stomach Upset	
	□ Hyperactivity	□ Colds/Pneumonia			
HAS HISTORY OF OR UNDER CARE FOR:	□ Heart Trouble		□ Appendicitis	□ Asthma	□ Epilepsy
	□ Stomach Ulcer		□ Bronchitis	□ Diabetes	□ Tonsillitis
	□ Nervous Disorder		□ Skin Disease	□ Hernia	□ Athlete's Foot
	□ Other (Please specify)				
Date of Tetanus Booster:			Does your youth have his/her appendix?		
Does your youth have his/her tonsils?			Does your youth wear glasses?		
Does your youth wear contacts?			Does your youth have a hearing aid?		
Does your youth have orthodontic devices?			Does your youth have any other oral devices?		
Swimming Ability:	□ Beginner	□ Intermediate	□ Advanced		
Any other information that would help youth and/or emergency staff:					
Reviewed by: **Date:**	**Reviewed by:** **Date:**		**Reviewed by:** **Date:**		
Reviewed by: **Date:**	**Reviewed by:** **Date:**		**Reviewed by:** **Date:**	**Youth 2009**	

Kirkwood United Methodist Church

Medical Release Form

Adult Volunteer

I, ____________________________, authorize another adult representing Kirkwood
(Print participant's name)
United Medical Church on this trip to consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment and/or hospital care rendered to me under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine by the state in which they practice, during the duration of the trip identified below:

Activity:_____________________________________ Dates: __________________________

My home physician:___________________________ Phone:__________________________

Allergies and/or Medications:____

My medical insurance (carrier and policy #):____

____

Insurer's Phone #:____

Signature of participant:_________________________ Date:___________________________

Notarization of Medical Release Form:

Sate of:____

County of:____

On this _________ day of ______________________, 20___, before me personally appeared_____

____

to me known to be the same person described in the who executed the within the instrument, and who acknowledged the same to be the fee act and deed thereof.

____

Notary Public, ________________________________ County

State of ______________________________________

My Commission expires:______________________