

United Methodist Church of Whitefish Bay Adult Volunteer Medical Release Form

This will be kept in a confidential file in the Youth Ministry Office. Please direct all questions to the Director of Youth Ministries, Melissa Swanson, by phone: (414) 964-2424, x137, or by email: mswanson@umcwf.org.

This Consent Form gives permission to seek whatever medical attention is deemed necessary and releases the United Methodist Church of Whitefish Bay and its staff of any liability against personal losses of named child.

I understand that there are inherent risks involved in any ministry or event and I hereby release the Church, its pastors, employees, agents and volunteer workers from any and all liability for any injury, loss or damage to person or property that may occur during the course. I consent to any reasonable medical treatment as deemed necessary by a licensed physician, should I not be able to make the decision myself. In the event that treatment is required from a physician and/or hospital personnel designated by the Church, I agree to hold such person free and harmless of any claims, demands or suits for damages arising from the giving of such consent. I acknowledge that I will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider.

Furthermore, I affirm that the health insurance information provided above is accurate at this date and will, to the best of my knowledge, still be in force at the time of the event.

Signature _____ **Date** _____

Printed Name _____

Please return this to the Church office or the Office of the Director of Youth Ministries. Thank you.

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PERSONAL INFORMATION

Name _____ Male ___ Female ___ Birthday _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Emergency Contact _____ Phone _____

Relationship to You _____

MEDICAL INSURANCE INFORMATION-Complete all that applies

Insurance Company _____ Phone _____

Subscriber ID# _____ Group # _____

Physician _____ Phone _____

Dentist _____ Phone _____

Please describe any physical and/or psychological conditions you may have that the staff should be aware of, and what, if any, action of protection is required. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

Check the following areas that apply to you. If necessary, add another page with details:

1. What is the year of your last tetanus vaccine? _____
2. List any and all medications you are currently taking _____
3. List all known allergies _____
4. List any dietary concerns _____
5. Do you suffer from or have ever experienced or are being treated currently for any of the following:
___asthma___diabetes___epilepsy/seizure disorder___frequent stomach problems___physical handicap___other
4. Do you wear ___prosthetics ___glasses ___contact lenses ___hearing aid

**PLEASE ATTACH A COPY OF YOUR MEDICAL INSURANCE
CARD TO THIS FORM.
REMEMBER TO READ AND SIGN THE BACK!!!**