ADULT MEDICAL RELEASE FORM
Fayetteville First United Methodist Church

Full Name: _____ Date of Birth: _____

Preferred Name to be called: _____ Male ( ) Female ( )

Address: _____ Home Phone: _____

City/Zip: _____ Cell Phone: _____

Email: _____

Emergency Contact: ***please circle the best way to contact.***

Name & Relationship: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

HEALTH HISTORY (Check all that apply) Attach additional sheet if necessary

	DISEASES:	**ALLERGIES:**
Frequent ear infections ____	Chicken pox ____	Hay fever, etc. ____
frequent colds/sore throats ____	Measles ____	Poison ivy/oak/sumac ____
Sinusitis/bronchitis ____	Mumps ____	Insect stings ____
Strep throat ____	German measles ____	Penicillin ____
Mononucleosis ____	Whooping cough ____	Aspirin ____
Heart defect/disease ____	Tuberculosis ____	other _____
Epilepsy/convulsions ____	Polio ____	Food _____
Bleeding/clotting disorders ____	Diabetes ____	

Hearing Aids _____

Defibrillator or pace maker _____

SUBJECT TO:

Asthma ____ Arthritis ____ Hypertension ____ Fainting ____

List any medications or drugs taken regularly including dosage (presently or recently):

_____ _____

_____ _____

_____ _____

PLEASE carry a current list of meds and dosage in your wallet when you attend trips.

Do you wear contact lenses? _____

Physician's name: _____ Phone: _____

INSURANCE INFORMATION

Name of policyholder: _____

Medical/Health insurance company name: _____

PLEASE INCLUDE a copy of your card.

Policy Number: _____ Group Number: _____

Preauthorization Phone Number: _____

In the event that I become ill, or am injured, or for any reason require medical treatment while attending a Fayetteville First United Methodist Church function or activity, I do hereby consent to any and all medical or surgical treatment, including anesthesia and operations, which may be deemed advisable by any qualified physician selected by agents or officials of Fayetteville First United Methodist Church. If there is required treatment for which a physician or other health care provider refuses to administer without my consent, I will hereby authorize the staff at Fayetteville First United Methodist Church or any other representatives of Fayetteville First United Methodist Church, to give such consent and further agree to hold any person harmless from any claims, demands, or suits of any nature arising from the giving of such consent, so long as the treatment is administered 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 company.

The intention of this release is to grant authority to administer and perform any and all examinations, treatments, anesthetics, operations, and diagnostic procedures which may now or during the course of the patient's care, be deemed advisable or necessary by any qualified physician. I will see that payment is made for all medical expenses incurred for medical treatment. This payment will be made by me or by my insurance company providing coverage.

I fully release Fayetteville First United Methodist Church, its authorized representatives, and staff from all liability of any kind and character upon any claim, demand, or cause of action which might be asserted in my behalf against said church, representatives, or staff.

Signature: _____ Date: _____

Sworn to and subscribed before me this _____ day of _____, _____.

Notary Public _____

PRINT, TYPE, OR STAMP COMMISSIONED NAME OF NOTARY PUBLIC