

## EMERGENCY MEDICAL RELEASE FORM

Name \_\_\_\_\_  
(Last) (First) (Middle Initial)

Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Phone #: Home(\_\_\_\_) \_\_\_\_\_

Male:\_\_\_ Female:\_\_\_ Age:\_\_\_

Parent's name (if under age 21): \_\_\_\_\_

Home email address: \_\_\_\_\_

Mom's Cell ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Dad's Cell ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Mom's Work ( ) \_\_\_\_\_

Dad's Work ( ) \_\_\_\_\_

Emergency and Health Information: (To be completed by all participants):

General: Do you have: (if "yes" – explain)

\_\_\_Yes \_\_\_No Allergies?

\_\_\_Yes \_\_\_No Asthma?

\_\_\_Yes \_\_\_No Heart condition?

\_\_\_Yes \_\_\_No Other?

Are you subject to: (if "yes" – explain)

\_\_\_Yes \_\_\_No Fainting?

\_\_\_Yes \_\_\_No Sleep walking?

\_\_\_Yes \_\_\_No Upset stomach?

\_\_\_Yes \_\_\_No Other?

Do you have reaction to: (if "yes" – explain)

\_\_\_Yes \_\_\_No Bee Sting?

\_\_\_Yes \_\_\_No Penicilin?

\_\_\_Yes \_\_\_No Other drugs?

\_\_\_Yes \_\_\_No Other?

\_\_\_Yes \_\_\_No Do you have any condition that prevents you from participating in any activities? Please list:

\_\_\_Yes \_\_\_No Are you diabetic?

\_\_\_Yes \_\_\_No Do you have any sight or hearing impairment?

\_\_\_Yes \_\_\_No Do you wear contact lenses?

Date of last tetanus shot: \_\_\_\_\_

**PLEASE COMPLETE PAGE 2**

Emergency Information: MUST BE INCLUDED

Health Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of another person to contact: \_\_\_\_\_ ( \_\_ friend \_\_ relative)

Address: \_\_\_\_\_

Telephone:(home) \_\_\_\_\_ (work) \_\_\_\_\_

Family doctor's name: \_\_\_\_\_

Doctor's office phone: \_\_\_\_\_

**Today's Date** \_\_\_\_\_

The undersigned does hereby give permisison for my (our) child, \_\_\_\_\_  
to attend and participate in activities sponsored by **Community Lutheran Church**.

I (we) authorize an adult, in whose care the minor has been entrusted, to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advise of any *physician or dentist* licensed under the provision of the *Medical Practice Act* on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree (s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for my (our) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

The undersigned does also hereby give permission for my (our) child to ride in any vehicle designated by the adult whose care the minor has been entrusted while attending and participating in activities sponsored by Community Lutheran Church.

It is my (our) expectation that I (we) will be contacted as soon as possible in the event of injury to my (our) child.

Participant Signature: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_