

EVANGEL BAPTIST CHURCH HAGERSTOWN, MD
MEDICAL FORM AND RELEASE STATEMENT

GENERAL INFORMATION

Name: _____ Age: _____ Sex: _____
Last First Middle

Home Address: _____
Street City State Zip

Parent/Guardian _____
Full Name

Parent/Guardian Address _____
Street City State Zip

Phone Home () _____ Work () _____

Alternate Contact Person _____
Street City State Zip

Phone Home () _____ Work () _____

Family Physician _____ Phone() _____
Full Name

Physician Address _____
Street City State Zip

In Case of Illness, Notify _____ Phone() _____
Full Name

MEDICAL INSURANCE

1. Are you or your child covered by any hospitalization and medical care policy. YES NO
2. Insurance Company _____
Name Local Agent
3. If group policy, name of company carried through. _____
4. Policy of Certificate Number _____ Renewal Date _____
5. In whose name is the insurance? _____

LIABILITY RELEASE STATEMENT

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I cannot be reached during the activity dates shown on the permission slip, I hereby give my permission to the physician or dentist selected by the activity leader to hospitalize, to secure medical treatment and/or to order an injection, anesthesia, or surgery for my child as deemed necessary.

I understand that my insurance coverage for my child will be used as primary coverage in the event medical intervention is needed. Coverage by Evangel Baptist Church through its accident policy will be used as a backup for what my family's insurance does not cover.

I understand all reasonable safety precautions will be taken at all times by Evangel Baptist Church and it's agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold Evangel Baptist Church, it's leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the activity listed on the permission slip.

Parent/Guardian Signature _____

Date _____

Signature of participant (If over 18 years of age)

MEDICAL HISTORY

1. List any illness or condition for which you are now under treatment and list any medications you are currently taking:

2. If you have had any of the following illnesses or injuries, state the year of the occurrence:

Arthritis Diabetes Heart Disease Rheumatic Fever
 Asthma Dislocations Hepatitis Tuberculosis
 Colitis Epilepsy Hernias Ulcers
 Concussion Convulsions Mononucleosis

3. Name any injuries, illnesses, disabilities or surgery not previously mentioned. State the year of the occurrence:

4. Describe your current physical condition and list any physical activities in which you regularly engage:

5. If you have now, or have had any of the following symptoms or conditions, circle "YES," underline and describe the problem. If not, circle "NO."

- a. Dizziness, loss of consciousness, or recurrent headaches. YES NO
b. Eye, ear, nose, throat, or sinus symptoms. YES NO
c. Impairment of sight, hearing, speech. YES NO
d. Chronic cough or coughing up blood. YES NO
e. Chest pain, shortness of breath, palpitation, swelling of ankles, murmur, high blood pressure. YES NO
f. Sensitivities (allergies) to horse serum (tetanus antitoxin) sulfa, penicillin, or other drugs or allergies. YES NO
g. Leg cramps, varicose veins or varicose ulcer. YES NO
h. Troublesome skin conditions. YES NO
i. Loss of teeth (indicate number of false teeth). YES NO
j. Symptoms related to gastrointestinal tract: recurring

- abdominal pain, diarrhea, passing of blood, etc. YES NO
k. Albumin, sugar or blood in urine, kidney stone or urinary difficulties. YES NO
m. Benign or malignant growth or tumor. YES NO
n. Allergic reaction to Bee or insect sting or bite. YES NO

Give details in regard to any of the above questions from "a-n" which you have circled "YES.":

6. List any medicines to which you are allergic:
