

**First Presbyterian Church, Stanley, NC  
Mission / Event Medical Release Form**

**Mission / Event:** Palmer Home for Children, Columbus, MS

**Dates:** 6/21/2008 to 6/28/2008 Phone # 1 (662) 328-5704

**Method of Transportation:** Church Bus Cost: \$200

**What to Bring:** Sleeping bag or twin sheets; toiletries; clothes you can get dirty; towels; goggles; work gloves; swim wear.

**Participant Information:**

Name \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_

**Health Insurance: \*\*\* ATTACH COPY OF INSURANCE CARD \*\*\***

Policy Holder's Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy # \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

**Emergency Contact Information:**

Name \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_

**Medical Checklist/Questions:** Please check if the participant has any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Asthma or Chronic wheezing                                    | <input type="checkbox"/> Mental Health Counseling           | <input type="checkbox"/> Kidney Problems                    |
| <input type="checkbox"/> Any other respiratory problems                                | <input type="checkbox"/> Fainting spells                    | <input type="checkbox"/> Tuberculosis                       |
| <input type="checkbox"/> Cysts or Tumors of any kind                                   | <input type="checkbox"/> Convulsions, epilepsy or seizures  | <input type="checkbox"/> Severe Knee Problems               |
| <input type="checkbox"/> Chronic or persistent cough                                   | <input type="checkbox"/> Parkinson's disease                | <input type="checkbox"/> Intestinal or bowel problems       |
| <input type="checkbox"/> Skin disorder other than acne                                 | <input type="checkbox"/> Anemia or any other blood disorder | <input type="checkbox"/> Cancer                             |
| <input type="checkbox"/> Attempted suicide   | <input type="checkbox"/> Serious bodily injury              | <input type="checkbox"/> Gall Bladder stones or colic       |
| <input type="checkbox"/> Intentionally inflicted harm on oneself                       | <input type="checkbox"/> Thyroid ailment                    | <input type="checkbox"/> Prostate problems                  |
| <input type="checkbox"/> Diabetes or Hypoglycemia (low blood sugar)                    | <input type="checkbox"/> Severe allergic reactions          | <input type="checkbox"/> Venereal disease                   |
| <input type="checkbox"/> Circulatory trouble   | <input type="checkbox"/> AIDS virus or HIV                  | <input type="checkbox"/> Breast or menstrual disorder       |
| <input type="checkbox"/> Hearing or Vision Impairment                                  | <input type="checkbox"/> High or Low Metabolism             | <input type="checkbox"/> High blood pressure/cardiac issues |
| <input type="checkbox"/> Persistent, recurring indigestion, stomach or duodenal ulcers |   | <input type="checkbox"/> Eating Disorder                    |
| <input type="checkbox"/> Any other disease or disability not listed above _____        |   |   |

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**Surgical History:**

1) Type of operation or illness: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Physician's Name: \_\_\_\_\_

Name and address of hospital: \_\_\_\_\_

1) Type of operation or illness: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Physician's Name: \_\_\_\_\_

Name and address of hospital: \_\_\_\_\_

3) Please provide any details pertaining to the participant's health not covered: (Attach additional sheets if necessary) \_\_\_\_\_

**Medications:** Taking Prescription or Non-Prescription Medication? If yes, specify:

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Allergies?: Specify: \_\_\_\_\_

Currently under physician's care? If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Date of last Tetanus booster: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Release and Consent Agreement:**

**Child Participant (under 18):**

Knowing that the adult sponsors will take utmost care of my child's safety, I understand that accidents do occur and that in such situations immediate steps must be taken to secure my child's health. I hereby authorize the staff (or designated leader) of First Presbyterian Church, Stanley to seek medical attention should an emergency arise for my child provided that I am contacted as soon as possible. Failure to reach me shall not prevent an application of immediate, necessary medical treatment, not excluding injection, anesthesia, or surgery for my child. I further agree that First Presbyterian Church shall be held harmless in the event of accident or injury, and in that regard, I understand and agree First Presbyterian Church, Stanley disclaims any and all liability in the unlikely event of injuries sustained in connection with this event.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

**Adult Participant:**

Knowing that the adult sponsors will take utmost care of my safety, I understand that accidents do occur and that in such situations immediate steps must be taken to secure my health. I hereby authorize the staff (or designated leader) of First Presbyterian Church, Stanley to seek medical attention, including an application of immediate, necessary medical treatment, not excluding injection, anesthesia, or surgery, should an emergency arise. I further agree that First Presbyterian Church shall be held harmless in the event of accident or injury, and in that regard, I understand and agree First Presbyterian Church, Stanley disclaims any and all liability in the unlikely event of injuries sustained in connection with this event.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date