Medical Release Form/

Permission to Treat

Name of Church:_____ City/State: _____

Name:_____ Social Security#:_____ Birth- date:____/____/_____ Age:____
Sex (M/F):_____
Address: _____ City:_____ State:_____
Zip:_____

Parent/Guardian: _____ Home Phone:(___)_____

Work Phone:(___)_____ Secondary contact to notify in event of
emergency:_____ Their relationship to you:_____ Their
phone:(___)_____

Please supply ALL of the following information.

Attach a copy of your insurance card.

Medical Insurance Co.:_____ Group#_____ Policy#:_____ CompanyPs
address:_____
CompanyPs Phone:(___)_____ City:_____ State:_____ Zip:_____

Family PhysicianPs Name:_____ Phone:(___)_____

Physical Limitations (Asthma, diabetes, allergies, etc.), and/or special instructions (Allergic to certain meds, rare blood type, wears contact lenses, etc.):

List ALL medication taken on a regular basis and/or any brought with you
to the conference (Prescription meds MUST have a pharmacy label and name of doctor):