

# Medical and Liability Release Form

Davidson United Methodist Church  
P.O. Box 718 | 233 South Main Street | Davidson, NC 28036  
704-892-8277 | www.davidsonumc.org



Date received in office: \_\_\_\_\_

Valid February 2010 - January 2011

## Participant Information

Name: \_\_\_\_\_ Gender: M F Date completed: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social security number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Home #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ - \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Employer: \_\_\_\_\_

Passport number (if applicable): \_\_\_\_\_ Passport expiration date: \_\_\_\_\_

## Emergency Contact Information \*Please list two contacts not traveling with you.

Contact #1 name: \_\_\_\_\_ Relation: \_\_\_\_\_

Cell #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Home #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ - \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Contact #2 name: \_\_\_\_\_ Relation: \_\_\_\_\_

Cell #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Home #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ - \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

## Medical Insurance Information \*Attach a front and back copy of your insurance card.

Medical insurance carrier: \_\_\_\_\_

Policy number: \_\_\_\_\_ Phone number: \_\_\_\_\_

Member number: \_\_\_\_\_ Group number: \_\_\_\_\_

## Physicians

Primary care physician: \_\_\_\_\_ Phone number: \_\_\_\_\_

Primary dentist: \_\_\_\_\_ Phone number: \_\_\_\_\_

Other: \_\_\_\_\_ Phone number: \_\_\_\_\_

## Health History

**Acknowledgement of Confidentiality** We realize that information contained in this form is sensitive and personal. Only paid staff and adult volunteers working directly with the participant named on this form will have access to this information. The more fully this form is completed, the better we will be able to serve and meet the participant's individual care needs.

### Allergies

Participant has no known allergies.

Participant has the following allergies (list ALL allergies, including food, medication, insect, latex, bee stings, seasonal, etc.):

Describe the reaction and what is done to manage it: \_\_\_\_\_

Participant carries an Epi pen.

If minor, name of guardian responsible for sending medication needed in response to allergic reaction: \_\_\_\_\_

### Diet

Participant has no dietary restrictions.

Participant has the following dietary restrictions:  Vegetarian  Does not eat dairy products  Other

Please specify: \_\_\_\_\_

**Chronic concerns** - Check all that apply and provide detailed supportive care information.

Participant has no chronic health concerns and is capable of full participation in this program.

Participant has the following chronic health concern(s):

AIDS/HIV

Diabetes

Heart trouble

Mobility challenges

Asthma

Fainting

Heat stroke

Poison ivy

Athlete's foot

Frequent colds

Hepatitis

Sunburns easily

Bleeding/clotting disorder

Frequent ear infections

Kidney trouble

Seizures

Bronchitis

Headaches

Menstrual cramps

Sleep walking

Other: \_\_\_\_\_

Other: \_\_\_\_\_

Upset stomach

Supportive care needed for each item checked: \_\_\_\_\_

**Tetanus Booster** - List month and year of participant's last shot: \_\_\_\_\_

### Medication

Participant does not take any medications on a regular basis.

Participant takes routine medication as follows (attach additional information, if needed):

Name of medication: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Reason for taking: \_\_\_\_\_

Reason for taking: \_\_\_\_\_

Dose: \_\_\_\_\_

Dose: \_\_\_\_\_

Time of day (if applicable): \_\_\_\_\_

Time of day (if applicable): \_\_\_\_\_

Name of medication: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Reason for taking: \_\_\_\_\_

Reason for taking: \_\_\_\_\_

Dose: \_\_\_\_\_

Dose: \_\_\_\_\_

Time of day (if applicable): \_\_\_\_\_

Time of day (if applicable): \_\_\_\_\_

Authorization for routine health care for minors:

My child is NOT allowed to take the following over-the-counter (OTC) medications - mark all that apply:

Advil/Motrin

Aspirin

Caladryl

Pamprin/Midol

Antacids

Benadryl - oral

Cough drops

Poison ivy treatment

After-bite/anti bug bite

Benadryl - topical

Decongestant

Sunscreen

Antibiotic ointment

Bug spray

Eye drops

Tylenol

If administered OTC medication, my youth should receive a (circle one) child / adult dosage.

My youth (Grades 7-12) will be responsible for their own medication(s).

I wish for adult leadership to administer my youth's medication.

\* For children (newborn to Grade 6), ALL medications (prescription and OTC) MUST be administered by adult leadership.

**Special Needs/Disability Awareness** - Check all that apply and provide detailed supportive care information.

- Participant has no special needs and is capable of full participation in this program.
- Participant has identified/diagnosed special needs - either for educational or medical reasons.
- My child/youth has a PCA at school and/or at home.
  - ADD
  - ADD/ADHD
  - Asperger's syndrome
  - Autism
  - Bi-polar disorder
  - Depression
  - Down's syndrome
  - Emotional/behavioral disability
  - Learning disability
  - Other: \_\_\_\_\_
  - Other: \_\_\_\_\_

Supportive care needed for each item checked: \_\_\_\_\_  
\_\_\_\_\_

**Medical and Liability Release Statement**

My child/youth has permission to receive routine first aid care and the prescription and/or OTC medication(s) indicated on this form during their participation in DUMC trips, outings, overnights, and retreats.

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 the emergency contacts cannot be reached, I hereby give permission to the physician or dentist selected by the activity leader to hospitalize, secure medical treatment, an injection, anesthesia, or surgery as deemed necessary.

I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold Davidson United Methodist Church, its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form.

\_\_\_\_\_  
PRINT NAME - participant (if age 18+), parent, or guardian

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
Date