



Medical Information/Release Form

Name _____ Age _____ Gender _____

Address _____ City _____

State _____ Zip _____ Phone _____ Email _____

SS# (for medical needs only) _____ Birthdate _____

Emergency Contact _____

Relationship _____ City of Residence _____

Phone _____

The undersigned hereby authorizes any staff member and or trip leader who may be supervising or directing any activity sponsored by the The Carpenter's Hope to seek emergency medical treatment necessary while you are participating in a TCH sponsored activity including travel to and from the activity.

If the above named person is a minor your signature authorizes the care on their behalf.

Signature _____ Date _____

Cell phone _____ Work _____

Medical Insurance Information

This information will be requested by the physician and medical facility in the event of an emergency. Please help us by assuring the information provided is complete and accurate. This medical release form is valid for one year for all TCH sponsored activities. If any of the information you have provided should change before this expiration date, please complete a new form and return it to the church office.

Participant _____

Parent or Guardian (for minor participant) _____

Policy carried under what name _____

Policy owner occupation _____

Employer _____ . Employer Phone _____

Employer Address _____

City _____ State _____ Zip _____

Insurance Carrier Name _____

Insurance Carrier Address _____

City _____ State _____ Zip _____

Policy Number _____ Group Number _____

Please list any medical issues _____

Please list medications and condition being treated _____

Please list any allergies to medications _____

Please list other allergies i.e. food, environmental, other _____

Please list any dietary requirements _____
(use back of form if necessary)

Date of last Tetanus Shot _____ (should be taken every 10 years)

Signature _____

Date _____