

'07-'08 FUMC Youth Ministry-Adult Counselor MEDICAL INFORMATION

Adult's Full Name \_\_\_\_\_  
Social Security No. \_\_\_\_\_  
Address \_\_\_\_\_  
City / Zip \_\_\_\_\_  
Occupation \_\_\_\_\_

Date of Birth \_\_\_\_\_  
Male( ) Female( ) Age \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

Person to contact in case of emergency:  
Name & relation \_\_\_\_\_  
Occupation \_\_\_\_\_

Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

Physicians Name \_\_\_\_\_ Phone: \_\_\_\_\_

HEALTH HISTORY (check all those that apply)

Frequent ear infections \_\_\_\_\_  
Frequent Colds / Sore Throats \_\_\_\_\_  
Sinusitis / Bronchitis \_\_\_\_\_  
Strep Throat \_\_\_\_\_  
Mononucleosis \_\_\_\_\_  
Heart Defect / Disease \_\_\_\_\_  
Epilepsy / Convulsions \_\_\_\_\_  
Bleeding / Clotting Disorders \_\_\_\_\_  
Hypertension \_\_\_\_\_  
Stomach Problems \_\_\_\_\_

DISEASES:  
Chicken pox \_\_\_\_\_  
Measles \_\_\_\_\_  
Mumps \_\_\_\_\_  
German Measles \_\_\_\_\_  
Whooping Cough \_\_\_\_\_  
Tuberculosis \_\_\_\_\_  
Polio \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Asthma \_\_\_\_\_  
Arthritis \_\_\_\_\_

ALLERGIES:  
Penicillin \_\_\_\_\_  
Aspirin \_\_\_\_\_  
Other \_\_\_\_\_  
Food \_\_\_\_\_  
Insect Stings \_\_\_\_\_  
Poison Ivy/Oak/Sumac \_\_\_\_\_  
Hay Fever, etc. \_\_\_\_\_  
**SUBJECT TO:** Sleep Walking \_\_\_\_\_  
Fainting \_\_\_\_\_ Bedwetting \_\_\_\_\_  
Constipation \_\_\_\_\_ Other \_\_\_\_\_

Other Diseases or Details of Above \_\_\_\_\_  
\_\_\_\_\_

Are immunizations up to date? \_\_\_\_\_ If no, please explain \_\_\_\_\_  
Date of last Tetanus Shot \_\_\_\_\_ Date of last TB skin test \_\_\_\_\_

Any activity limitations? \_\_\_\_\_ Do you wear contacts? \_\_\_\_\_  
Any specific activities to be encouraged? \_\_\_\_\_  
Any specific activities to be restricted? \_\_\_\_\_  
List any medications or drugs taken regularly \_\_\_\_\_  
\_\_\_\_\_

Any special medical or dietary regime to be continued? \_\_\_\_\_  
\_\_\_\_\_

MEDICAL RELEASE & INSURANCE INFORMATION  
Valid August 1, 2007 to August 31, 2008

Name of Adult Counselor \_\_\_\_\_  
Insurance issued in the name of \_\_\_\_\_  
Medical/Health Insurance Co. Name: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number : \_\_\_\_\_  
Preauthorization Phone # \_\_\_\_\_

I certify in the event I become ill, am injured, or for any reason require medical treatment while attending a First United Methodist Church function or activity, I do hereby consent to any and all medical or surgical treatment, including anesthesia and operations, which may be deemed advisable by any qualified physician selected by agents or officials of the First United Methodist Church. In the event treatment is called for which a physician or other health care provider refuses to administer without my consent, I hereby authorize the Staff at First United Methodist Church or any other representatives of First United Methodist Church, to give such consent and further agree to hold any person harmless from any claims, demands, or suits of any nature arising from the giving of such consent so long as the treatment is administered by or under the supervision of a licensed physician. I further authorize the release of the listed medical information to appropriate medical personnel and/or the health coverage insurance company.

The intention of this release is to grant authority to administer and perform any and all examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the course of the patient's care, be deemed advisable or necessary by any qualified physician. I will see that payment is made for all medical expenses incurred for medical treatment for the above named person. This payment will be made by myself or by my insurance company providing coverage for the above-named person.

I the undersigned, certify that I can participate in all activities, of any nature, sponsored by First United Methodist Church for the 2007-2008 school calendar year. I fully release First United Methodist Church, its authorized representatives and staff from all liability of any kind and character upon any claim, demand, or cause of action that might be asserted in my behalf against said church, representatives or staff.

Signature of Participant: \_\_\_\_\_ Date \_\_\_\_\_  
Sworn to and subscribed before this \_\_\_\_\_ day of \_\_\_\_\_ .

NOTARY PUBLIC

State of Alabama, My commission expires:

\_\_\_\_\_  
PRINT, TYPE OR STAMP COMMISSIONED NAME  
OF NOTARY PUBLIC

Personally known \_\_\_\_\_ or \_\_\_\_\_ Produced Identification (list type)