

**California-Nevada Annual Conference
The United Methodist Church
ADULT MEDICAL FORM**

The following information is required for all adult participants. Information is confidential and will be made available only to those adults who are directly responsible for the participant's care. *For their safety and well-being, no participant will be allowed to be part of the event without a completed and **signed** Medical Authorization and History Form.*

Name _____ **Male Female** (please circle)

Birth Date _____

Home Address _____

City _____ State _____ Zip _____

Home Phone () _____

In case of an emergency, please contact:

Name _____ Relationship _____

Home Phone () _____

Work Phone () _____

Family Physician _____ Phone () _____

Insurance Carrier/Plan Name _____ Policy ID # _____

Carrier Address _____

Date of Last Tetanus shot _____ Date of last physical examination _____

Please list any allergies: _____

Taking any medications: Yes No Please list: _____

Is the participant under the direct care of a physician or is there any condition we need to be aware of? _____

Please explain: _____

RELEASE STATEMENT

I, _____ the undersigned, do hereby authorize the adult leaders acting on behalf of the California-Nevada Annual Conference of The United Methodist Church, as agent, and working with other non profit agencies or the City of Sacramento, to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s), especially in case of emergency, to give specific consent to any such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his or her judgment may deem advisable. I agree to pay for any medical, dental, surgical, or hospital diagnosis, treatment, or care rendered to me.

_____ Volunteers Signature

_____ Date