2017 CUMC ADULT MEDICAL INFORMATION FORM

NOTE: This form seeks authorization to make medical related decisions for you while attending the activities and events sponsored in whole or in part by Christ United Methodist Church during the 2017 ministry year. Unless specified below, this authorization, when signed, will remain in full force and effect for any CUMC activity or event until expressly revoked in writing and delivered to the Office of Youth Ministry at CUMC.

Name:_____ Date of Birth:_____

Address:_____ City/Zip:_____

Home Phone: _____ Cell Phone: _____

Cell Carrier:_____ E-mail: _____

Spouse's Name:_____

Spouse's Cell:_____

Other Emergency Contact:_____ Cell Phone:_____

You are covered under hospitalization insurance Y or N

_____ (name of company) pursuant to

Policy No._____in the name of

_____

_____

Family Doctor is:_____

Address:_____

City:_____State:_____Zipcode:_____

Telephone:_____

Reaction to drugs:_____

_____

Allergies:_____

Physical defects or limitations:_____

_____

Blood type (if known):_____

Other medical information which might be necessary to the proper care of yourself:_____

_____

Any medicine that you are presently taking:_____

_____

I do hereby authorize the CUMC Youth Ministry to make provision for any medical care which may be deemed necessary by a licensed physician for myself and to make decisions or give any other consents which may be necessary for my health and welfare at any time.

_____ _____

Signature Date