TRINITY LUTHERAN CHURCH

206 E. Badger Street, Waupaca, WI 54981

YOUTH MEDICAL RELEASE AND CONSENT FORM

(Each participant must complete this form)

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ ZIP: _____ PHONE: _____

NAME OF PARENT(S)/GUARDIAN(S): _____

NAME OF PHYSICIAN: _____PHONE_____

NAME OF DENTIST: _____PHONE: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____PHONE:_____

(Please photocopy insurance cards and include with this form)

CURRENT MEDICATIONS TAKEN BY PARTICIPANT (LIST NAME AND DOSAGE):

_____

HEALTH HISTORY: (MAJOR ILLNESSES, LAST TETANUS SHOT, ALLERGIES, ETC.)

_____

_____

FATHER EMPLOYED AT: _____PHONE: _____

MOTHER EMPLOYED AT: _____PHONE: _____

EMERGENCY CONTACT INFORMATION*:*

NAME: _____PHONE:_____

ADDRESS: _____CITY:_____

RELATIONSHIP TO PARTICIPANT: _____

Dear Parent or Guardian:

This form will be presented to the attending physician if your child needs medical treatment in your absence. This will prevent delay of treatment with your signature and photocopied insurance card.

Parent/Guardian (name) _____ "I hereby authorize the treatment, administration of anesthesia and surgical treatment for my child (name) _____ in the event of a medical emergency occurring during my absence or when hospital or medical personnel can not contact me. This authorization extends to all medical facilities and personnel regardless of setting, in or out of a medical facility, in the treatment of my minor child."

Signature of Parent/Guardian_____Date: _____

Signature of Witness _____Date: _____

TRINITY LUTHERAN CHURCH
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ADULT MEDICAL RELEASE AND CONSENT FORM

(Each participant must complete this form)

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

NAME OF PHYSICIAN: _____ PHONE: _____

NAME OF DENTIST: _____ PHONE: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____
(Please attach a photocopy of your insurance card)

CURRENT MEDICATIONS TAKEN BY PARTICIPANT (LIST MEDICATION AND DOSAGE):
_____

HEALTH HISTORY (MAJOR ILLNESSES, LAST TETANUS SHOT, ALLERGIES, ETC.):
_____

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP: _____

PHONE (PRIMARY): _____SECONDARY: _____

This form will be presented to the hospital and attending physician if you need medical treatment and are unable to consent. This will prevent the delay of treatment with your signature and photocopied insurance card.

I hereby authorize the treatment, administration of anesthesia and surgical treatment for myself _____
(Print name)

In the event of medical emergency occurring when I can not respond for myself due to injury, accident or illness. This authorization extends to all medical facilities and personnel regardless of setting and/or facility in the treatment of me if I am incapacitated to respond my direct wishes for medical treatment.

_____

Signature of participant Date

_____

Signature of Witness Date