



Adults

Embracing Louisville

Medical Authorization and Release
(participants 19 and over)

Kentucky Woman's Missionary Union (KY WMU)

We must have this form completed in case of medical emergency

Name _____

Birthdate _____ **Age** _____ **Email Address** _____

Phone Numbers (please list at least one number):

Home _____ **Work** _____ **Cell** _____

Home Address _____

City _____ **State** _____ **Zip Code** _____

Physician Information **Name** _____

Address _____

Phone _____

Emergency Phone Contact **Name** _____

Day _____ **Evening** _____

Name _____

Day _____ **Evening** _____

Please list any current medical conditions that are being treated or any chronic condition

Please list currently prescribed medications (please include concise directions, such as dosage/frequency)

List any illnesses/special instructions/pertinent facts that physicians should know

Last date of tetanus or booster shot _____

Please list allergies, including food (Be specific)

Each volunteer is expected to have primary health care insurance in case of an accident, injury, or illness. Personal liability is the responsibility of the volunteer. Please list your insurance information and provide a copy (front/ back of the card [s])

Insurance Information:

Insurance Company _____ Policy Number _____

Insurance Company _____ Policy Number _____

Beneficiary for Trip Insurance _____

Consent/Release

In the event of an accident, injury, or sickness, as a result of which I am unable to make my own medical decisions, during participation of the event or related events, I hereby authorize any Kentucky WMU employee agent or volunteer (WMU representative) to seek medical attention for me. In addition, I hereby give my permission to be treated by a licensed physician if medical treatment is deemed necessary by the physician. In case of surgical emergency, I also give my consent to medical procedures diagnosed and prescribed by the attending licensed physician. I understand that WMU does not employ professional medical staff during its events or offer medical treatment/services. To the extent my insurance does not cover any treatment provided, I accept responsibility for all treatment rendered.

Participants Name _____

Signed _____ **Date** _____

Email _____

