Student

Embracing Louisville

Medical Authorization and Release
(participants 18 and under)
Kentucky Woman's Missionary Union

We must have this form completed in case of medical emergency

Name _____ **Age** _____

Birthdate _____ **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 proive a copy (front and back of the card [s])

Insurance Information:

Insurance Company_____ Policy Number _____

Insurance Company _____ Policy Number _____

Beneficiary for Trip Insurance_____

Consent/Release

I/We the undersigned have legal custody of the minor named above. In the event of accident, injury, or sickness during the minor's participation in the event or related events, I/we hereby give permission for the minor to be treated by a licensed physician if medical treatment is deemed necessary by the physician. In case of surgical emergency, I/We also give consent to medical procedure diagnosed and prescribed by the attending licensed physician. I/We understand that Kentucky WMU does not employ professional medial staff during its events or offer medical treatment/services. To the extent the above-named minor's insurance does not cover any treatment provided, I/We accept responsibility for payment all treatment rendered.

Name of Custodial Parents/Guardians _____

Parent Signature _____ **Date**_____

Email_____

Kentucky WMU