

MEDICAL RELEASE FORM

Name:				DOB:		
Address:			Home Phone: ()			
City:	State:	ZIP:	Work Phone: ()			
Email:						
Doctor's Name:			Doctor's Phone: ()			
Address:						
City:	State:	ZIP:				
Current Medication:						
Allergies (Example: Foods? Me	dications? Bee/W	/asp Stings?)				
Medical Insurance Company:			Phone: ()			
Insurance Agent:			Policy #			
Address:		City:	ty:		ZIP	:
Please attach copy of insurance card to this release form.						
Signed:						
Date:						
***Complete only if team membe	r is under age 18*	***				
Parent or Guardian: Phone:						
Address:			_			
Street	City	City		ate ZI)
I hereby give my permission for			to be treated by competent			
medical personnel because of any	accident or medica	al emergency while	e involveo	d on the UMCC	R Sa	ger Brown
mission journey.						
Signature:	······	· · · · · · · · · · · · · · · · · · ·				
Date:						· · · · · · · · · · · · · · · · · · ·
Print Name:						
Relationship to Youth:						