ST. MATTHEW MEDICAL RELEASE FOR ADULTS

NAME _____ SEX:_____

ADDRESS:_____

BIRTH DATE: _____ AGE:_____ SOCIAL SECURITY # _____

HOME PHONE # (____) _____ SPOUSE/PARENT (____)_____

CHURCH YOU BELONG TO:_____ WEEKEND YOU MADE: _____

NEXT OF KIN: _____ ADDRESS:_____PHONE# _____

TWO EMERGENCY PHONE # (____) _____ (____) _____

NAME & RELATIONSHIP TO ABOVE # _____

PERSONAL PHYSICIAN'S NAME_____ PHONE #_____

PHYSICIAN'S ADDRESS: _____

MEDICATIONS I CANNOT TAKE_____

MEDICATIONS I AM PRESENTLY TAKING:_____

_____

ALLERGIES, SPECIAL HEALTH PROBLEMS : _____

_____

RESPONSIBLE PARTY'S EMPLOYER_____PHONE # _____

INSURANCE COMPANY:_____ POLICY # _____

ADDRESS: _____

NAME OF INSURED: _____

I UNDERSTAND THAT ST. MATTHEW EMMAUS/P.I.E. DOES NOT CARRY ACCIDENT OR MEDICAL INSURANCE ON PARTICIPANTS. I AGREE THAT MY INSURANCE COMPANY WILL BE USED FOR SUCH MEDICAL CARE AND I AM AWARE THAT I MAY BE BILLED BY THE MEDICAL PROVIDER FOR ANY MEDICAL TREATMENT NOT COVERED BY MY INSURANCE.

I UNDERSTAND THAT THERE IS A ZERO TOLERANCE OF ANY TYPE OF DRUG OR ALCOHOL AT THIS EVENT. IF I BEHAVE INAPPROPRIATELY, I WILL BE ASKED TO LEAVE AND I AGREE TO LEAVE IMMEDIATELY.

SHOULD AN EMERGENCY ARISE AND TREATMENT BECOME NECESSARY,
I HERE BY GIVE MY PERMISSION TO BE TREATED.

SIGNATURE:_____ DATE: _____