

First United Methodist Church 2011-2012 Health Form (Adult)

NAME OF ADULT:				
HEALTH STATEMENT ... Please fill this out so that we might be more fully aware of your special needs and to facilitate any medical attention that might be required while on the event/trip.				
Emergency Contact Name:			Home Phone # with area code:	
Full Mailing Address: (include county, please)				
Work Phone #(s) with area code and names:				
Cell Phone #(s) and names:				
Physician's Name:			Phone #:	
Dentist's Name:			Phone #:	
Restrictions on activities: Please specify	<input type="checkbox"/> None	<input type="checkbox"/> Sports	<input type="checkbox"/> Swimming	<input type="checkbox"/> Hiking
Other (please specify):				
RESTRICTIONS ON DIET:				<input type="checkbox"/> Vegetarian
MEDICATIONS CURRENTLY TAKING:				
ARE THERE ANY MEDICATIONS YOU SHOULD <u>NOT</u> BE GIVEN at event/trip? (ex. Aspirin, throat lozenge, laxatives) If yes, please specify. <input type="checkbox"/> yes <input type="checkbox"/> no				
ALLERGIES:	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa or other	<input type="checkbox"/> Tetanus shots	
<input type="checkbox"/> Food (specify)	<input type="checkbox"/> Poison Ivy/Oak	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Bee or insect sting	
<input type="checkbox"/> Other (specify)				
SUBJECT TO:	<input type="checkbox"/> Fainting	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Headaches	<input type="checkbox"/> Swimmer's ear
	<input type="checkbox"/> Earaches	<input type="checkbox"/> Toothaches	<input type="checkbox"/> Cramps	<input type="checkbox"/> Nose bleeds
	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Sleepwalking	<input type="checkbox"/> Stomach Upset	
	<input type="checkbox"/> Other (please specify):			
HAS HISTORY OF OR UNDER CARE FOR:	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Stomach ulcer
	<input type="checkbox"/> Hernia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other
	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Skin Disease	<input type="checkbox"/> Nervous Disorder	
	<input type="checkbox"/> Other (please specify):			
Date of tetanus shot/booster:		Do you have your appendix?		
Do you have your tonsils?		Do you wear a hearing aid?		
Do you wear corrective lenses?		Do you have a pacemaker?		
Any other information that would help staff better understand/relate to your current health condition:				

Over, please. 

The following information is necessary should you need treatment.	
Name:	
Social Security Number:	
Date of Birth (MM/DD/YYYY):	
County and State of Birth:	
Personal Health Insurance Policy Name and Number	

**TREATMENT CONSENT
FOR FIRST UNITED METHODIST EVENTS/TRIPS**

I/we understand that this experience includes my transportation consent for travel to and from any event.

In the event that I am unable to speak for myself, I grant permission to the adults attending the event from First United Methodist Church to seek emergency treatment for me by a licensed physician or hospital in the case of illness, accident, or injury, and grant them permission to release any information requested for the completion of medical/surgical or accident claims for me.

I further agree not to hold First United Methodist Church, or any adult youth workers thereof, responsible for any accident or illness that might occur to me while attending or traveling to and from the event sponsored by First United Methodist Church.

Notary Seal

Signature Date

****IMPORTANT: THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC IN ORDER TO BE VALID.**

Notary Public Date

Office Use Only:

Date Received:

Initials:

<p>CONSENT FOR USE OF PHOTOGRAPHS FOR PRINT, VIDEO, OR WEBSITE MEDIA</p> <p><input type="checkbox"/> I consent to allow all pictures taken of myself, _____, to be used for publicity and/or outreach materials for First United Methodist Church. I hereby indemnify and hold the above organization harmless against any and all claims or damages arising out of taking or use of any pictures or names of myself.</p> <p>_____ Signature Date</p> <p><input type="checkbox"/> I DO NOT consent to the above use of photographs for print, video, or website media.</p>

Over, please. 