RIVERSIDE MEDICAL RELEASE FORM

Legal Name: _____ Birthdate: ___/___/_____ Gender: ____

Home Address:_____

Home Phone: _____ Cell Phone: _____

Email: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Home Phone:_____

Cell Phone: _____ Work Phone:_____

Relationship to Participant: _____

MEDICAL INFORMATION

Primary Physician: _____ Phone #r: _____

Insurance Company: _____ Policy #: _____

Name of person Insurance is under: _____ Group #: _____

HEALTH HISTORY

Do you have any physical limitations that would hinder your ability to participate in vigorous activities? If so, please explain:

_____

_____

Do you have any medical problems? If so please explain.

_____

_____

Do you take any medication on a regular basis? If so, please list.

_____

_____

Are you allergic to any medications or food? If so please explain.

_____

_____

CONSENT FOR EMERGENCY TREATMENT (signature required from participant, or parent or guardian if under 18) In case of emergency, I herby give permission to the physician selected by Riverside Community Church representative to hospitalize secure proper treatment for and order injection, anesthesia, or surgery for myself/my child (ward) as name above. I also herby give permission for my child to participate in all activities, travel, service projects, and other activities.

Participant (or Parent/Guardian) Signature: _____ Date: _____