

MURRYSVILLE ALLIANCE CHURCH

Medical Release Form

Name:	
Birthdate:	
Name of Parent/Guardian (if under 18):	
Address:	
City: State:	Zip: Phone:
In Emergency, contact:	
Phone:	Pager/Cell Phone:
Name of Doctor:	Phone:
Name of Dentist:	Phone:
HEALTH HISTORY	
Allergies: () Insect Stings () Drugs	() Other
Other Conditions:	
() Heart condition ()Chronic asthma	() Frequent upget stemach
() Hay fever	() Frequent upset stomach () Epilepsy
() Diabetes	() Physical handicap
() Other:	``
If you checked any of the above, please gallergic reactions):	give details (i.e. include normal treatment of
Date of last tetanus shot:	
Name and dosage of any medications:	
Any swimming restrictions? Yes	No
Any activity restrictions? Yes	No
If yes, please specify restrictions:	

Our church's insurance is only secondary insurance. If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while your son or daughter is on a church-related activity.

Do you have health insurance? If yes, please fill out the following:	Yes	No
Name of the insured:		
Name of Insurance:		
Policy Number:		
Address of insurance company:		
Phone Number of insurance company: _		
Do you have a prescription plan? If yes, name of pharmacy:		
Phone number of pharmacy:		
cannot be reached in an emergency during my permission to the physician or dentis	ng the c t selecte nister a	inor or the emergency contact for the adult lates specified on this form, I hereby give ed by the church leadership to hospitalize, in injection, anesthesia, or surgery for my
Signature of Participant (if 18 or older) of	or Pare	nt/Guardian:
Date:		

THIS FORM VALID FROM January 1, 2024 until December 31, 2024