



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:**

- |  |   |
|--|---|
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Frequent colds         |
| <input type="checkbox"/> Chronic asthma  | <input type="checkbox"/> Frequent upset stomach |
| <input type="checkbox"/> Hay fever       | <input type="checkbox"/> Epilepsy               |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Physical handicap      |
| <input type="checkbox"/> Other: _____    |   |

If you checked any of the above, please give details (i.e. include normal treatment of allergic reactions): \_\_\_\_\_  
\_\_\_\_\_

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?                      Yes    No**

**If yes, please fill out the following:**

**Name of the insured:** \_\_\_\_\_

**Name of Insurance:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Address of insurance company:** \_\_\_\_\_

\_\_\_\_\_

**Phone Number of insurance company:** \_\_\_\_\_

**Do you have a prescription plan?                      Yes    No**

**If yes, name of pharmacy:** \_\_\_\_\_

**Phone number of pharmacy:** \_\_\_\_\_

**"In the event that the parent/guardian of the minor or the emergency contact for the adult cannot be reached in an emergency during the dates specified on this form, I hereby give my permission to the physician or dentist selected by the church leadership to hospitalize, to secure proper treatment, and/or administer an injection, anesthesia, or surgery for my son/daughter or myself as deemed necessary."**

**Signature of Participant (if 18 or older) or Parent/Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**THIS FORM VALID FROM January 1, 2025 until December 31, 2025**