UMCOR Sager Brown

MEDICAL RELEASE FORM

Name			Age	M or F
Address			Home Phone ( )	
City	State	Zip	Work Phone ( )	
Email				

Doctor's Name		Doctor's Phone ( )
Address		
City	State	Zip
Current Medication		
Allergies (*Example: Foods? Medications? Bee/Wasp Stings?)*		

Medical Insurance Co			Phone ( )	
Insurance Agent			Policy #	
Address	City		State	Zip
Please attach copy of insurance card to this release form.				

Signed: ______________________________

Date: ______________

Complete only if team member is under age 19

Parent or Guardian______________________________ Phone______________

Address____
Street City State Zip

I hereby give my permission for ______________________ to be treated by competent medical personnel as a result of any accident or medical emergency while involved on the UMCOR Sager Brown mission trip.

Signature______________________________

Date______________________________

Print Name ______________________________

Relationship to Youth______________________________