Broadway UMC
1323 Melrose St.
Bowling Green, KY 42104
(270) 843-3942

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Medical Form

Name of Minor _____Birthdate_____
Address_____ Grade_____
City_____ State_____ Zip Code_____
Parent's Phone_____ cell _____ _____
Business_____ cell_____
Notify in Case of Emergency_____
Phone Number_____ Relationship_____
Health/Accident Insurance Company_____
City_____ State_____ Zip Code_____
Policy Number_____ Group Number_____
List any allergies (food, drugs, pollen, etc.)

_____

_____

Tetanus Toxin (date last given)_____
Have you had any serious illness or surgeries in the past year? Yes No
(If yes, please list on separate sheet and attach.)
List any condition that a physician treating you should be aware of and medication you are taking: _____

_____

Family Doctor_____ Phone_____
Address_____
City_____ State_____ Zip Code_____

I give permission for this minor to travel with adults assigned as Broadway United Methodist Youth leaders. While in their care, I give my permission for them to seek professional care in case of medical or dental emergency.

Signature_____ Date_____

Attach copy of Insurance Card.

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Name of Participant _____

I / we the undersigned, are the parents having legal custody or the legal guardianship of the above named participant, a minor, have given legal consent for him / her to be transported by and in custody of staff or volunteers of Broadway United Methodist Church. In the event that he/she is injured while attending the trip and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed healthcare professional. In the event that treatment is required, I / we agree to hold the church staff and volunteers and Broadway United Methodist Church free and harmless of any claims, demands, or suits for damages arising from the giving of such consent so long as treatment is administered by or under the supervision of a licensed healthcare professional. I/ we also acknowledge that I/we will be ultimately responsible for any cost of medical care should that care not be reimbursed by my health insurance carrier.

Parent / Guardian Signature_____

Student's Full Name_____**Date of Birth**_____

Home Address_____**Phone**_____