Emergency Information Form – General

To be completed by all youth and adult participants of ministry outreach.

Youth Group Coordinators, please keep originals with your files during trip.

Name:

____

Last   First

Age:______________Date of Birth:__/___/___School Grade in Spring/year of event: _______

Gender: [ ]F [ ]M [ ]Trans* (*If not out, please check the gender you usually present) Email:

Cell Phone:_____________________________ ______________________________

Home Church:__________________________________Church City:_____________________________

Primary Emergency Contact for youth (Parent/Guardian); for adults (Spouse/Partner/Family/Friend):

Name: ____

Cell number:__________________________Home/other contact number(s): _______________________

Other Emergency Contact: Name:_______________________________Relationship:________________

Cell number(s):__________________________Other contact number(s): _______________________

Health Insurance Company:____Policy #:________________

Group #:______________Name of Policy Holder:____

Doctor's Name:__________________________________Telephone:_______________________________

Current medications: List name, dosage, frequency. (if needed use additional sheet)

For Parents/Legal Guardian: [ ] Youth may self-administer above medications.
[ ] Group Coordinator or designated chaperone may assist as needed.

Permission **is** [ ] *or* **is not** [ ] granted [**check one**] for this youth to receive OTC medications from trip coordinator as needed. **Parent/Legal Guardian initials**: ________

Health History: List all conditions, including but not limited to allergies, sleepwalking, convulsions, diabetes, mononucleosis, epilepsy, mobility issues, emotional problems or hyperactivity, fatigue, headaches, dizziness. Please indicate how long since last occurrence of problem. Use additional paper if necessary.

By signing this form I verify that the health/medical and insurance information provided on this form is true, accurate and complete. In case of medical emergency, I give permission to the physician(s) selected by my/my youth's group coordi- nator to secure proper medical treatment for the participant named on this form. I agree to pay additional costs that arise from such medical treatment if not covered by insurance.

Signature of Parent/Legal Guardian (for youth); or Adult Participant: _______________________________________

IMPORTANT INSTRUCTIONS

A copy of this medical release form should be kept by the group coordinator for youth. Adults are responsible for keeping a copy of these records on their person.

ADDITIONALLY

Please **email** *one* PDF copy to **humanresources@ucc.org**

([*]along with *one* copy of all Covenants and Medical Release Form)

THANK YOU!