REACH 2010

Adult Medical Release Form

(age 18 and over)

Name: ________________________________ Age: ____________ Birthdate: ________________

Address: ____

City: _____________________ State: __________ Zip Code: _______________

Phone: (Home) _________________________ (Cell) _______________________

Emergency Contact: ____

Emergency Contact Phone: ____

To whom it may concern: The undersigned __________________________ plans to attend and participate in Reach 2010 Local Mission Project on July 6-11, 2010.

I authorize the consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, necessary under the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agrees to pay all cost and expenses incurred in connection with such medical and dental services rendered to the undersigned pursuant to this authorization.

Should it be necessary for me to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

Hospital Insurance Yes No Insurance Company ____

Policy Number ______________________________

____

Participant Date

Medication you are taking: ____

Medication you are NOT to take: ____

Other allergies: ____

____

Date of last tetanus shot: ____