

**St. Paul's UCC
19th St. and Lincoln Ave.
Northampton, PA 18067**

Medical Release Form

This information will be kept confidential and used only in the event of a medical emergency during this authorized activity sponsored by St. Paul's. At the conclusion of the activity, this form will be shredded.

Event Name _____

Event Date _____

Name of Participant _____ Male Female

Address: _____

Birthdate: _____ Age: _____

Phone Number: _____

Parent's Name: _____

Address: _____

Phone Number: _____

Cell Phone: _____

Emergency Contact Person _____

Relationship _____

Address _____

Day Phone number _____

Evening Phone Number: _____

If the Emergency contact Person cannot be contacted, the following person can be called:

Name: _____

Relationship: _____

Address: _____

Day Phone Number: _____

Evening Phone Number: _____

An attempt will be made to reach the emergency contact person, however, in the event that this person cannot be reached and _____ needs medical treatment while attending this event, I hereby authorize a responsible adult assisting him/her, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care at a licensed hospital which is deemed advisable by, and is rendered under the general or special supervision of any physician and/or surgeon licensed to practice medicine.

Family Physician: _____

Phone Number: _____

Address _____

Date of Last Tetanus Shot _____

Is there a history of any illness or disability such as diabetes, epilepsy, allergies, asthma, etc?

If yes, please

explain _____

Is the participant presently taking any medications? If yes, please specify_____

Have you had any recent medical problems: ie sprains, fractures, or concussions? If yes, please explain_____

For those under 18 years of age: Tylenol/Aspirin Permission.....I hereby give permission to Staff/Designated Adult to give:

Administer Tylenol as needed	Yes_____	No_____
Administer Aspirin as needed	Yes_____	No_____

Prescription medication, please designate when and dosage.

Signature of participant_____

Signature of Parent (if participant is under 18)

Date_____