

NEW LIFE LUTHERAN CHURCH

4380 Wakonda Dr., Norwalk, IA 50211

ADULT MEDICAL RELEASE AND CONSENT FORM

(Each participant must complete this form)

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

NAME OF PHYSICIAN: _____ PHONE: _____

NAME OF DENTIST: _____ PHONE: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____ PHONE: _____

(Please photocopy insurance cards and include with this form)

CURRENT MEDICATIONS TAKEN BY PARTICIPANT (LIST NAME AND DOSAGE):

HEALTH HISTORY: (MAJOR ILLNESSES, LAST TETANUS SHOT, ALLERGIES, ETC.):

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP: _____

PHONE (PRIMARY): _____ SECONDARY: _____

This form will be presented to the attending physician if you need medical treatment and are unable to consent. This will prevent delay of treatment with your signature and photocopied insurance card.

I hereby authorize the treatment, administration of anesthesia and surgical treatment for myself (name) _____
In the event of a medical emergency occurring when I cannot respond for myself due to injury, accident or illness. This authorization extends to all medical facilities and personnel regardless of setting, in or out of a medical facility, in the treatment of me if I am incapacitated to respond my direct wishes for medical treatment.

Signature of participant _____ Date _____

Signature of Witness _____ Date _____