New Life Lutheran Church
4380 Wakonda Dr
Norwalk, IA
ADULT MEDICAL RELEASE AND CONSENT FORM

Name:_____ DOB: __/__/__

Address:_____

City: _____State:_____ZIP:_____

Cell Phone: (____)(____)(_____) Home Phone: (____)(____)(_____)

Name of Physician: _____Phone: (____)(____)(_____)

Name of Dentist:_____ Phone: (____)(____)(_____)

Insurance Company_____

Policy Number :_____Phone:(____)(____)(_____)

(please photocopy insurance cards and include with this form)

List all current medications (prescription and non-prescription)include name and dosage:_____

_____

Health History: (Major illnesses, allergies, etc._____

_____

_____Date of Last Tetanus Shot__/__/__

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.
1 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:_____

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