

**HIGHLAND PARK UNITED METHODIST YOUTH MINISTRY**  
**EMERGENCY MEDICAL INFORMATION**

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**PERSONAL INFORMATION**

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Participant's Name: \_\_\_\_\_ Date Of Birth M/D/Y \_\_\_\_/\_\_\_\_/\_\_\_\_  
Home Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
City/State/ Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Parent/Guardian Name(s): \_\_\_\_\_  
Mom's Work #: (\_\_\_\_) \_\_\_\_\_ Dad's Work #: (\_\_\_\_) \_\_\_\_\_

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**MEDICAL INFORMATION**

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Any current medical conditions or problems? \_\_\_\_\_  
\_\_\_\_\_  
Any allergies to Medications or Foods? \_\_\_\_\_  
Taking any prescribed medication? \_\_\_\_\_ If so, describe: \_\_\_\_\_  
\_\_\_\_\_  
Past medical history/injuries we should be aware of: \_\_\_\_\_  
\_\_\_\_\_  
Date of last Tetanus shot: \_\_\_\_\_  
Name of physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

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**INSURANCE INFORMATION**

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Group Or Family Hospitalization Insurance Company: \_\_\_\_\_  
Insurance Company's Address: \_\_\_\_\_  
Agent's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Insured's Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Insured's Date of Birth  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
In Case Of **EMERGENCY** (If Parent Can't Be Reached) **CALL**: \_\_\_\_\_  
Day Phone Number: \_\_\_\_\_ Night Phone #: \_\_\_\_\_

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**WAIVER OF RESPONSIBILITY**

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I \_\_\_\_\_ give permission to HPUMC youth staff or volunteer to authorize medical treatment for my child if I am unable to be reached. I understand that attempts will be made to reach me and the information I have given above is accurate and current. I release this person from any liability that arises from the consent given for my child. I also understand that I am responsible for all medical bills that arise. I release the church, its staff, and volunteers of any liability in the event of accident or injury.

Signed: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_