Beyond Sunday Mission
Medical Release Form

<u>Two copies of this form must be made. One copy should be given to Beyond Sunday Mission Staff upon arrival, the second copy must be kept in the site vehicle with the participant</u>

Name:_____
Phone:_____ Birth Date: (m)___(d)___(y)_____
Address:_____
_____

Emergency Contact:

Name:_____ Relationship:_____
Address_____

Day phone: _____ On trip with you: ☐ Yes or ☐ No
Evening phone: _____

Alternate contact:

Name:_____Relationship:_____
Address_____

Day phone:_____ Evening phone:_____

Medical Information:

Medications you currently take _____
_____

Medications you CANNOT take: _____

Allergies/special health problems or concerns:_____
_____
_____

Insurance information:

Insurance company:_____ Phone:_____
Address:_____
Policy No:_____ Group No: _____
Subscriber name:_____

Physician's name:_____ Phone:_____
Address:_____

Beyond Sunday Mission highly recommends checking the date of your last Tetanus shot and updating if necessary (every 5 years)
Date of last Tetanus shot:_____

In the event of a situation in which medical treatment is required while participating in Beyond Sunday Mission or a related activity, every reasonable effort will be made to contact the persons listed above. If Beyond Sunday Mission is unsuccessful in contacting the persons listed above, I give my consent/permission for Beyond Sunday Mission to act in any emergency requiring medical attention, including rendering first aid treatment on site and/or requesting treatment by medical personnel. I hereby waive and release Beyond Sunday Mission, its agents, employees, and any and all persons connected therewith, from any liability or claims relating to any injuries, illness or loss of property connected in any way with my participating in the mission and/or receiving any medical treatment.

To the extent I have any medical conditions needing prescription or over the counter drugs, I give permission for Beyond Sunday Mission to administer such drugs to the Participant listed below.

Further, consent/permission is hereby given to the following persons to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery (under recommendation of qualified personnel) in the event the above cannot be reached.

1._____
2._____
3. Physician chosen by Beyond Sunday Mission Staff

I agree that my insurance company will be billed for such medical care. I agree I am responsible for the cost of any medical treatment not covered by my insurance.

Parent/Guardian Signature:_____
Relationship to minor:_____Date:_____

Participant Signature:_____

☐ I certify that I am 18 years of age or older