

Metro Atlanta Project

Adult Emergency Medical Information

Date turned in: _____

Personal Information

Participant's Name: _____ Date of Birth M/D/Y: ____/____/____
Home Address: _____ Home Phone: (____) _____
City/State/Zip: _____ Social Security #: _____ - _____ - _____
Cell Phone #: _____
Spouse's Name: _____ Spouse's Cell #: (____) _____
Spouse's Work #: (____) _____

Medical Information

Any current medical conditions or problems? _____

Any allergies? If so, what happens? _____
_____ For insect stings, have EpiPen? _____
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 #: _____

Insurance Information

Group or Family Hospitalization Insurance Company: _____
Insurance Company's Address: _____
Agent's Name: _____ Phone #: _____
Group #: _____ Policy #: _____
In case of EMERGENCY (If Spouse Can't Be Reached) CALL: _____
Day Phone Number: _____ Night Phone Number: _____

Waiver of Responsibility

I, _____, hereby release the church, its staff, and volunteer counselors of any liability in the event of accident or injury to myself.

Signature: _____ Date: _____

Power of Attorney

I, _____, of the County of _____, State of Georgia, do hereby appoint the youth director as my agent as my true and lawful attorney in fact to act for me and in my name, place and stead; and to do any and all acts and exercise and all powers that I might or could do in giving consent to emergency medical treatment for me that he/she shall deem proper or advisable to do or exercise on my behalf.

This Power of Attorney and appointment of the authorized adult sponsor as my attorney-in-fact for the limited purpose or consenting to emergency medical treatment for myself shall not terminate on my physical or mental disability subsequent to the date of execution hereof.

IN WITNESS WHEREOF I have hereunto set my hand this _____ day of _____, 20____,

Signed: _____

IMPORTANT: SIGN IN THE PRESENCE OF A NOTARY PUBLIC

Notarization

BEFORE ME, the undersigned authority, on this day personally appeared _____, known to me to be the person whose name is subscribed to the above and forgoing instrument and acknowledged to me that he/she executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 20____.
_____, Notary Public.

Credit Card Information (Optional)

(This information will be kept confidential)

Each person on a church trip will need a means of paying for emergency medical treatment. Most hospitals will file on the insurance and use the power of attorney to authorize treatment, but some will require payment in advance. If you would like credit card information kept on file in the case of an emergency, please include this information below:

Credit Card Company: _____ Name as it appears on card: _____

Credit Card Number: _____ Date of Expiration M/Y: ____/____