Name/Address of Diocesan Institution Sponsoring Activity _____

ROMAN CATHOLIC DIOCESE OF OWENSBORO, 600 Locust St., Owensboro, KY 42301

EMERGENCY MEDICAL RELEASE AND HEALTH INFORMATION FOR ADULTS

(To be kept current and stored with youth forms, readily available if needed during youth activities)

****An adult may choose to limit or not include health information, but the form still needs to be collected. Emergency care may rely on information as presented here.**

FULL NAME (Please print) _____ **Birthdate** ____/____/____

Home Address (street, city, zip) _____

Home Phone_____ Work/Cell Phone_____ Email_____

Preferred Means of Communication: Phone Call ☐ Text ☐ Email ☐

Pre-existing or present medical conditions, disabilities, physical handicaps, or major illnesses:_____

_____

_____

Name and dosage of any **medications** that must be taken:_____

_____

_____

Any allergies (food, latex, animals, etc?) Yes_____ No_____ Allergic to any medications? Yes_____ No_____

If yes, please list and describe allergies:_____

Do you carry an EpiPen? Yes_____ No_____ If yes, where is it located?_____

Date of last tetanus shot_____ Contact lenses? Yes_____ No_____

Swimming restrictions? Yes_____ No_____ If yes, describe: _____

Activity restrictions? Yes_____ No_____ If yes, describe: _____

Health Insurance Company (covering above-named individual): _____

Insurance Policy #: _____ Group #: _____

Name of Policy Holder: _____ Date of Birth of Policy Holder: _____

Policy Holder's Place of Work: _____

Emergency Contacts:

Name _____ Relationship _____ Phone_____

Name _____ Relationship _____ Phone_____

In case of medical or surgical emergency, I hereby request and give my permission to the Catholic Diocese of Owensboro for hospitalization and/or provision of necessary medical treatment. I understand that I am responsible for the cost of any medical treatment (including surgery) received. I hereby release the directors and staff of this event from all responsibility for sickness or accidents which occur during the event.

*** Please understand that, depending upon the seriousness of the situation, you may be transported to the nearest hospital.**

Signature:_____ Date:_____

You are responsible for the accuracy of all information on this form. Please notify the appropriate leader of any changes (e.g. insurance policy changes, changes in medical condition or medicines, court orders, etc.).