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.).