

**FOREST PARK
COMMUNITY CHURCH**

Medical Information & Release

This form MUST be filled out in order for you to participate in a Forest Park mission trip.

Full Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

email address _____

Medical Insurance Provider _____

ID # _____ Group # _____

Primary Physician _____ Phone _____

Address _____

City _____ State _____ Zip _____

Emergency Contact _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

email address _____

Medical conditions from which you suffer _____

Physical Limitations (please list) _____

Rx or OTC medication taken on a regular basis _____

Allergies _____

Special Dietary Needs _____

In the event of an emergency I give my permission to a licensed physician to hospitalize, anesthetize or perform surgery. I understand that every effort will be made to inform my emergency contact before these actions are taken.

Signed _____ Date: _____

Parent / Guardian (if under 18) _____ Date _____

Relationship to participant _____