

Form B: Emergency Medical Release and Health Information for Adults (Rev. 2/2019)

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.).**