



Participant Medical Information

Group/Church Name _____ Group Leader _____

Participant's Name _____ M/F _____ Grade (Next Fall) _____

Date of Birth _____ E-mail _____

Parents/Guardians: First _____ Last _____

Home Address _____

City _____ State _____ Zip _____

Parents/Guardians Home Phone # (_____) _____ Parents/Guardians Work Phone # (_____) _____

Parents/Guardians Cell Phone # (_____) _____ Parents/Guardians Other # (_____) _____

In the event of an emergency, if you are unable to reach me at the above number, contact:

Name: _____

Relationship: _____ Phone # (_____) _____

MEDICAL HISTORY (PLEASE HAVE YOUR INSURANCE CARD WITH YOU AT ALL TIMES)

Allergies: _____

Current Medications: _____

Medical Conditions: _____

Insurance Carrier: _____

Insurance Policy Number: _____

Name of Insured: _____ Relationship to Participant: _____

EMERGENCY MEDICAL TREATMENT:

- ❖ In the event of an emergency, I hereby give permission to Alive In You, Inc., its officers, directors, agents, volunteers and representatives associated with this event to transport my child to a doctor or hospital and hereby authorize medical treatment, including but not in limitation to emergency surgery or medical treatment, and assume the responsibility of all medical bills, if any.
- ❖ I relieve Alive In You, Inc., of all responsibility and consequences that may arise as a result of this treatment. I will not hold Alive In You, Inc., liable in the event of injury. Further, I agree to accept any and all financial responsibility as a result of medical treatment.

Participant Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____
(if participant is under 21 years of age)