



**Soapstone United Methodist Church**  
**Information, Permission and Medical Release Form**



**Name** \_\_\_\_\_ Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Last First Mid. Initial

Address \_\_\_\_\_  
Street City State Zip Code

Phone: \_\_\_\_\_ Email \_\_\_\_\_

Social Sec. # \_\_\_\_\_ Preferred Name \_\_\_\_\_

**Contact in case of emergency:**

**Name** \_\_\_\_\_ Relationship \_\_\_\_\_  
Last First Mid. Initial

Address \_\_\_\_\_  
Street City State Zip Code

Home ( \_\_\_\_\_ ) \_\_\_\_\_ Work ( \_\_\_\_\_ ) \_\_\_\_\_ Cell ( \_\_\_\_\_ ) \_\_\_\_\_

**Medical Information (Please attach a copy of your medical insurance card.)**

Date of last Tetanus shot \_\_\_\_\_ Medications you **cannot** take: \_\_\_\_\_

Allergies/special health problems or concerns: \_\_\_\_\_

\_\_\_\_\_

Insurance \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Policy # \_\_\_\_\_ Policy Holder's Identification # \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Physician \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Dentist \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

**Permissions**

In the event of an emergency or non-emergency situation in which medical treatment is required as a result of participation with Soapstone United Methodist Church, every reasonable effort will be made to contact the persons listed on the reverse side. If unsuccessful in contacting the persons listed, consent/permission is given for treatment by competent medical personnel.

Further, and unless specified otherwise, consent/permission is hereby given to all accompanying adult volunteer leaders to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery (under recommendation of qualified medical personnel).

I understand that Soapstone United Methodist Church does not carry accident or medical insurance on participation volunteers. I agree that my insurance company will be used for such medical care expenses. I am aware that I may be billed by the medical provider for any medical treatment expenses not covered by my insurance coverage and that I am responsible for the payment of any medical bills.

This is the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_ .

Personally appeared before me, \_\_\_\_\_  
a Notary Public of \_\_\_\_\_ County in the State of \_\_\_\_\_,  
the persons whose signatures appear above and with whom I am personally acquainted and acknowledge  
that he/she executed the within instrument for the purposes therein contained.

Witness my hand and official seal this \_\_\_\_\_ day  
of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
*Notary Public*

My Commission Expires:  
\_\_\_\_\_