

**Life Bridge Children's Ministry**  
**Adult Medical Liability Release and Medical History Form**

I (being 18 years of age or older) understand that in the event medical intervention is needed, every attempt will be made to contact the persons listed on this form. In the event that they cannot be reached, and I am unable to communicate, I hereby authorize an adult leader to consent to the physician or dentist selected by the adult leader to hospitalize, to secure medical treatment and/or to order an injection, anesthesia, X-rays, or surgery on my behalf as deemed necessary.

Furthermore I hereby give an adult leader with Life Bridge Church consent for Emergency Medical Services (911) to be contacted in the event of a medical emergency. I give consent to Life Bridge Church for transportation on my behalf by ambulance if deemed necessary.

I further understand that my insurance coverage will be used as primary coverage in the event medical intervention is needed. Any policy of the church or organization sponsoring this event will be used as the secondary coverage.

I understand all reasonably safety precautions will be taken at all times by Life Bridge Church and its agents. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold Life Bridge Church, its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by myself.

Volunteer/Worker Name (print) \_\_\_\_\_

Birth date \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_

(I have read the foregoing and agree to the terms established on this form)

Signature \_\_\_\_\_ Date \_\_\_\_\_

Emergency contact \_\_\_\_\_ phone # (\_\_\_\_) \_\_\_\_\_

Insurance company \_\_\_\_\_ policy # \_\_\_\_\_

Physician \_\_\_\_\_ physician phone # (\_\_\_\_) \_\_\_\_\_

Dentist \_\_\_\_\_ Dentist phone # (\_\_\_\_) \_\_\_\_\_

Hospital preference \_\_\_\_\_

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*Please complete this form so staff and health providers can be aware of and best care for your health needs. If necessary, describe in detail any physical and/or psychological ailment, illness, susceptibility, weakness, limitation, handicap, disability, or condition to which you are subject to. Please list any action or protection that may be required to care for your needs.*

Please circle any of the following conditions that you may have:

ALLERGIES:

Bee Stings

Penicillin

Dairy

Poison Ivy, Oak, Sumac

Nuts

Pollen

Peanuts

Other Drugs/Medications: \_\_\_\_\_

Other: \_\_\_\_\_

MEDICAL CONDITIONS:

Asthma

Hypo - glycemia

Diabetes

Motion Sickness

Eczema

Nose Bleed

Epilepsy

Upset Stomach

Fainting

Seizures

Headaches

Other: \_\_\_\_\_

Heart

\_\_\_\_\_

SPECIAL CONDITIONS:

ADD

Fears

ADHD

ODD

Anxiety

Sleeping disorders

Bi- polar

Hearing Impairment

Glasses or Contact lenses

Physical handicap

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Do you have any condition that might prevent you/your child from participating in any particular activity?

No                      Yes    (if yes, please explain) \_\_\_\_\_  
\_\_\_\_\_

For your safety please circle one of the following that best describes you:

Good swimmer      Fair swimmer      Non swimmer

Date of your last tetanus shot: \_\_\_\_\_ Blood type: \_\_\_\_\_

Please list any specific care you may need in the event of a medical emergency concerning any of the previously selected conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medications and doses that you are taking:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____