FORM B (1 page)

ROMAN CATHOLIC DIOCESE OF OWENSBORO, 600 Locust St., Owensboro, KY 42301

Name/Address of Institution Sponsoring Activity _____

EMERGENCY MEDICAL RELEASE AND HEALTH INFORMATION FOR ADULTS

HEALTH HISTORY:

FULL NAME (Please print) _____ **Birthdate** ____/____/____

Address _____ **Phone** _____

Any 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, explain: _____

Date of last tetanus shot_____ Contact lenses? Yes/No _____

Any swimming restrictions: _____Yes _____No What?_____
_____

Any activity restrictions? _____Yes _____No What_____
_____

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.

Name of Health Insurance Company: _____
Insurance Policy #: _____ Insurance Certificate #: _____

* **Please understand that, depending upon the seriousness of the situation, you may be transported to the nearest hospital.**

Signature:_____ Date:_____

Name someone who may be contacted in case of emergency.

Next of Kin/Guardian _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone: _____

IF THERE ARE ANY CHANGES IN THE INFORMATION ON THIS FORM, IT IS YOUR RESPONSIBILITY TO NOTIFY THE APPROPRIATE LEADER AND GET THE FORM UPDATED. (e.g. insurance policy changes, changes in medical condition or medicines, etc.)

Revised August 2010