 

**MEDICAL RELEASE FORM**

Revision: August 21, 2024

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| --- | --- | --- | --- | --- | --- |
| **Name:**  Last |       | First |       | Middle |       |
| **Address:** |       | City |       | State |       | Zip |       |
| **Phone**: (H) |       | (C) |       | (W) |       |
| **Date of Birth**  |       | **Spouse Name** |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Emergency Contacts**  | Spouse Cell |       | Spouse Work |       |
| 1) |       | Relationship |       | Phone |       |
| 2) |       | Relationship |       | Phone |       |

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| **Church**:  |       | City |       | Phone |       |
| **Pastor:** |       | Phone (H) |       | Cell |       |

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|  | **Physician**:  |       | Phone |       |
|  | **Medical Insurance Co.** |       | Policy # |       |
|  | **MEDICAL HISTORY** | **Year Date of Last Tetanus Shot**  |  |
|  | ☐ | Allergy (explain reaction) | ☐ | Broken bone (explain) | ☐ | Kidney disease |
|  |  | Food/Meds/Plant/Insect | ☐ | Diabetes | ☐ | Mononucleosis |
|  | ☐ | Asthma | ☐ | Dizziness/Fainting | ☐ | Past surgery (explain) |
|  | ☐ | Back pain | ☐ | Headaches | ☐ | Seizures |
|  | ☐ | Blood pressure - high/low | ☐ | Heart disease (explain) | ☐ | Stroke |
|  | ☐ | Blood disorder (explain) | ☐ | Hepatitis A/B/C | ☐ | Other (explain) |
| Please explain the above noted health problems and any additional medical conditions of which TXM team leaders need to be aware:  |
|       |
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|  | **MEDICATION:** List medications taken on a regular basis with dosage and time to be taken |
|  |       |       |       |
|  |       |       | **Use back of form if more room is needed** |

**YOUR SIGNATURE BELOW AFFIRMS THE FOLLOWING:**

The above information is accurate to the best of my knowledge. I understand this form will be kept by Texans on Mission team leaders for use, if needed. I give permission to release information to medical personnel, if necessary. Should I be unconscious, I give permission to a TXM representative to act as spokesperson in granting permission for emergency treatment (including anesthesia), if necessary.

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| **Signature** |  | **Date** |       |