 

**MEDICAL RELEASE FORM**

Revision: August 21, 2024

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | |  |

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **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: | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | **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.

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