

ADULT HEALTH RELEASE FORM

Name _____

Date of Birth _____

Home Phone _____ Mobile Phone _____

Home Address _____

City _____ State _____ Zip _____

Business Address _____

Business City _____ Business State _____ Business Zip _____

Emergency Contact #1: _____ Relationship _____ Telephone _____

Emergency Contact #2 _____ Relationship _____ Telephone _____

Name of Personal Physician _____ Telephone _____

Personal Health/Accident Insurance Carrier _____ Policy No. _____

Current Medications Taken _____ Dosage _____

CONCERNS OR SPECIAL DIET NEEDS:

ADULT PARTICIPANT AUTHORIZATION: In the event my contacts cannot be reached in an emergency situation, I hereby give permission to the physician selected by the program leaders to secure and administer medical or surgical treatment under local and general anesthesia, including hospitalization for the person named above. I hereby waive and release Buncombe Street United Methodist Church and its staff from any and all liability for any injury or illness incurred during the activity.

DISCLAIMER LANGUAGE

You consent that any photos, video or sound recordings made during the activities may be used by Buncombe Street United Methodist Church (BSUMC) activities are the sole property of BSUMC and may be used by us for any legal purpose without payment to you. Such uses may involve the inclusion of such photos, video or sound recordings in any materials (including our website, publications, promotions, advertisements, or other materials), whether as originally taken or as modified by us.

Signature _____ Date _____