

## 2018 CUMC ADULT MEDICAL INFORMATION FORM

**NOTE: This form seeks authorization to make medical related decisions for you while attending the activities and events sponsored in whole or in part by Christ United Methodist Church during the 2018 ministry year.**

**Unless specified below, this authorization, when signed, will remain in full force and effect for any CUMC activity or event until expressly revoked in writing and delivered to the Office of Youth Ministry at CUMC.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Cell Carrier: \_\_\_\_\_ E-mail: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Cell: \_\_\_\_\_

Other Emergency Contact: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

You are covered under hospitalization insurance Y or N

\_\_\_\_\_ (name of company) pursuant to  
Policy No. \_\_\_\_\_ in the name of

Family Doctor is: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Telephone: \_\_\_\_\_

Reaction to drugs: \_\_\_\_\_

Allergies: \_\_\_\_\_

Physical defects or limitations: \_\_\_\_\_

Blood type (if known): \_\_\_\_\_

Other medical information which might be necessary to the proper care of  
yourself: \_\_\_\_\_

Any medicine that you are presently  
taking: \_\_\_\_\_

**I do hereby authorize the CUMC Youth Ministry to make provision for any medical care which may be deemed necessary by a licensed physician for myself and to make decisions or give any other consents which may be necessary for my health and welfare at any time.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date