Westminster Presbyterian Church
Dayton, OH

ADULT MEDICAL CONSENT FORM

Name _____ Age _____ Birth date _____

Mailing Address _____
Street Address

_____
City State Zip code

Phone Numbers _____

E-mail address _____

Social Security Number (optional) _____

To whom it may concern:

I the undersigned do hereby willingly wish to attend and participate in the 2009 Post-High Trip to Chicago, Illinois sponsored by Westminster Presbyterian Church May 22 – 24, 2009.

The undersigned consents to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physicians or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered.

Should it be necessary for the undersigned to return home due to medical the undersigned shall assume all transportation costs.

Hospital Insurance ____ Yes ____ No Policy Number _____

Insurance Company _____

Emergency Contact _____ Phone _____

Relationship _____

Emergency Contact _____ Phone _____

Relationship _____

FORM CONTINUES

Please list all medications you will be bringing and their purpose:

Please list detailed instructions for the administration of these medications:

Please list any medical conditions you have that we should be aware of, along with instructions for assisting you if you should have a medical emergency.

Please list all allergies.

Please list anything that will limit your participation in planned activities, along with any other information you feel we should have.

_____ _____

Participant's Signature Date

_____ _____

Witness's Signature Date