

EXTENDED MEDICAL - *For an 18 year or older ADULT-*  
**AUTHORIZATION AND RELEASE FORM**

The Lamb's Chapel @ Haw River Christian Church  
415 Roxboro Street, Haw River, NC 27258 336-578-0291

_____
NAME
Home Phone # (_____) _____
Cell # (_____) _____
Cell # (_____) _____

**PURPOSE OF THIS FORM:**

This form gives licensed physician consent to give treatment in the case of an emergency while the person listed here is involved with any event or trip associated with The Lamb's Chapel @ Haw River Christian Church. If an emergency arises, every effort will be made to notify the nearest family. This form releases the church, church officials, members and other adult chaperones of any liability in the event any student or adult is injured or has a medical emergency that occurs while on a church-related trip. This form is good for one year following the stated date of signature.

I have read all the literature about the event/trip. I furthermore authorize the Pastor, Associate Pastor, Youth or Children's Pastor and/or other adult chaperones to seek medical treatment on my behalf if necessary.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Please print Full Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Telephone Numbers: 1. \_\_\_\_\_ 2. \_\_\_\_\_

*(Another relative/person to contact - someone not going on this trip/event with you)*

E-mail address: \_\_\_\_\_

**MEDICAL INFORMATION:**

<b>ALLERGIES:</b> Please check below IF you have sensitivity or <b>allergies</b> to: <input type="checkbox"/> Bee Sting <input type="checkbox"/> Nuts <input type="checkbox"/> Dairy <input type="checkbox"/> Latex  <input type="checkbox"/> Other _____  Required medications: _____ _____
<b>CONDITIONS:</b> Please check below IF you have: <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Kidney Injuries <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Heart Condition <input type="checkbox"/> Other Medical Conditions: _____  Required medications: _____ _____
Other medications: _____

Physician: _____
Physician's Telephone: _____
Insurance Company: _____
Policy #: _____

<b>For Notary Only</b>
_____ County, North Carolina
I certify that the following person, _____ personally appeared before me this day, acknowledging to me that he or she voluntarily signed the foregoing document for the purpose stated therein and in the capacity indicated.
This _____ day of _____, _____
My commission expires: ____/____/____
_____ NOTARY PUBLIC SIGNATURE & SEAL
_____ PRINT / TYPE NOTARY NAME

Please see further medical or other needed information written on the back of this form (or attached to this form)