

# SOUTHERN BAPTIST DISASTER RELIEF - REGION 4A

Arkansas, Texas-TBM, Texas-SBTC, Missouri, Louisiana, Oklahoma

## MEDICAL RELEASE FORM

|                      |  |                    |  |               |            |
|----------------------|--|--------------------|--|---------------|------------|
| <b>Name: Last</b>    |  | <b>First</b>       |  | <b>Middle</b> |            |
| <b>Address:</b>      |  | <b>City</b>        |  | <b>State</b>  | <b>Zip</b> |
| <b>Phone: (H)</b>    |  | <b>(C)</b>         |  | <b>(W)</b>    |            |
| <b>Date of Birth</b> |  | <b>Spouse Name</b> |  |               |            |

|                          |                    |                     |              |
|--------------------------|--------------------|---------------------|--------------|
| <b>Emergency Contact</b> | <b>Spouse Cell</b> | <b>Work</b>         |              |
| 1.)                      |                    | <b>Relationship</b> | <b>Phone</b> |
| 2.)                      |                    | <b>Relationship</b> | <b>Phone</b> |

|                    |             |                  |             |
|--------------------|-------------|------------------|-------------|
| <b>Church:</b>     | <b>City</b> | <b>Phone</b>     |             |
| <b>Association</b> |             |                  |             |
| <b>Pastor:</b>     |             | <b>Phone (H)</b> | <b>Cell</b> |

|                   |              |
|-------------------|--------------|
| <b>Physician:</b> | <b>Phone</b> |
|-------------------|--------------|

|                              |                 |
|------------------------------|-----------------|
| <b>Medical Insurance Co.</b> | <b>Policy #</b> |
|------------------------------|-----------------|

| MEDICAL HISTORY                                     | Year                     | Date of Last Tetanus Shot |   |
|---|--------------------------|---------------------------|---|
| <input type="checkbox"/> Allergy (explain reaction) | <input type="checkbox"/> | Broken Bone (explain)     | <input type="checkbox"/> Kidney Disease         |
| <input type="checkbox"/> Food/Meds/Plant/Insect     | <input type="checkbox"/> | Diabetes                  | <input type="checkbox"/> Mononucleosis          |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> | Dizziness/Fainting        | <input type="checkbox"/> Past Surgery (explain) |
| <input type="checkbox"/> Back Pain                  | <input type="checkbox"/> | Headaches                 | <input type="checkbox"/> Seizures               |
| <input type="checkbox"/> Blood Pressure High/Low    | <input type="checkbox"/> | Heart Disease (explain)   | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Blood Disorder (explain)   | <input type="checkbox"/> | Hepatitis A/B/C           | <input type="checkbox"/> Other (explain)        |

Please explain the above noted health problems and any additional special medical conditions of which the Unit Leader (Blue Cap) should be aware: (may use back if needed)

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|   |  |  |
|---|--|--|
| <b>MEDICATION:</b> List medications taken on a regular basis with dosage and time to be taken |  |  |
|   |  |  |
|   |  |  |
|   |  | <b>Use back of form if more room is needed</b> |

**THE FOLLOWING STATEMENT WILL BE SIGNED WHEN THE UNIT IS ACTIVATED**

*The above information is accurate to the best of my knowledge. I understand this form will be kept by the Unit Leader (Blue Cap) for use if needed. I give permission to release information to medical personnel if necessary. Should I be unconscious, I give permission to a Southern Baptist Disaster Relief representative to act as spokesman in granting permission for emergency treatment (including anesthesia) if necessary.*

|                  |             |
|------------------|-------------|
| <b>Signature</b> | <b>Date</b> |
|------------------|-------------|