

# MEDICAL INFORMATION/RELEASE FORM

For Adults and Youth

Mail completed form to: **EDGE OUTREACH, 1500 Arlington Ave., Louisville, KY 40206.**

*This form MUST be filled out in order for you to participate in an EDGE OUTREACH mission trip.*

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Email \_\_\_\_\_

Medical Insurance Provider \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Email \_\_\_\_\_

If above person is unavailable, then please contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Email \_\_\_\_\_

Please check if you suffer from any of the following medical conditions:

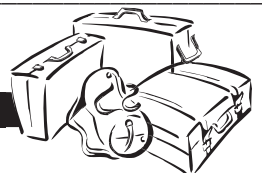
- |                                       |                                       |  |  |                                    |
|---------------------------------------|---------------------------------------|--|--|------------------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Seizures     | <input type="checkbox"/> Glaucoma     | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Chronic Anxiety         |                                    |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Depression        | <input type="checkbox"/> Other (describe): _____ |                                    |

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

Physical limitations (please list): \_\_\_\_\_

List any medications (prescription or OTC) taken on a regular basis: \_\_\_\_\_

(Please complete and sign back page)



List allergies (*insect, medications, food, environment, plant, etc.*): \_\_\_\_\_

List any special dietary needs: \_\_\_\_\_

Have you had any surgeries in the past three years?     Yes     No

If so, please list: \_\_\_\_\_

I hereby authorize and release to EDGE OUTREACH the use of my, or my child's, image in any photograph or video recording for any purpose of EDGE OUTREACH.

I hereby give permission for any qualified guide or medical personnel to render necessary emergency medical care for myself, or my child if a minor. I also give them permission to make any necessary judgment decisions.

If a dispute arises from or relates to this contract or the breach thereof and if the dispute cannot be settled through direct discussions, I agree to endeavor first to settle the dispute in an amicable manner by mediation administered by the American Arbitration Association under its Commercial Mediation Rules before resorting to arbitration. Thereafter, any unresolved controversy or claim arising from or relating to this contract or breach thereof shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. The arbitrator shall award to the prevailing party, if any, as determined by the arbitrators, all of its costs and fees.

I agree that the site of the Mediation/Arbitration shall be Louisville, KY. The terms of this agreement shall continue and be in effect after the trip has ended.

I do not and will not hold EDGE OUTREACH or its leaders or chaperones responsible for any accidents, injuries or claims arising from this activity.

In an emergency, I give my permission to a licensed physician to hospitalize, anesthetize or perform surgery. I understand that every effort will be made to inform my emergency contact before these actions are taken.

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

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
*(only if participant is under 18 years of age)*

Relationship to participant \_\_\_\_\_