OKLAHOMA DISTRICT COUNCIL
OF THE ASSEMBLIES OF GOD

Medical Form

This form is required for all attendees.

*****This form is two-sided***** *****Please fill out in INK*****

EVENT: _____

Office Use Only	
MEDS	
HOLDS	

Church City: _____ Church Name: _____

Attendee Name: (First, Middle Initial, Last) _____

Address: _____ City, State, Zip: _____

Gender: (Circle One) Male Female	Date of Birth: (mm/dd/yyyy)	Age:	If student, 2018-2019 Grade:

Emergency Contact Information

First Contact Name: _____ Relationship: _____

Cell Phone: _____ Additional Contact Number: _____

Second Contact Name: _____ Relationship: _____

Cell Phone: _____ Additional Contact Number: _____

Medical Information

Medical Insurance Provider: _____

Policy Number: _____ Group Number: _____

Physician's Name: _____ Phone: _____

List all allergies/medical conditions and any special considerations of which we should be aware:

_____

_____

May the attendee listed above be given over-the-counter, non-prescription medications or applications, not to exceed recommended dosage for stomach discomfort, burns, cuts, insect bites, rash, scrapes, or other minor ailments? (Circle One) Yes No

Both sides of this form must be completed & signed!

Attendee Name: _____ Church & City: _____

- ALL MEDICATION MUST BE IN THEIR ORIGINAL CONTAINERS WITH A CURRENT/CORRECT LABEL.
- Please only send the amount needed for the length of the event.
- Pills sent in plastic baggies or weekly dose containers will not be given.
- Expired medication will not be given.
- All inhalers, nasal sprays, and epi-pens must be in the original box with the prescription label. (If the box is not available, ask the pharmacy to print a label.)
- All medication, vitamins, supplements, and oils must be stored in the First Aid Station.
- All medication, vitamins, supplements, and oils must be administered by the First Aid Staff in the First Aid Station.

NO MEDICATION, VITAMINS, SUPPLEMENTS, OR OILS WILL BE ADMINISTERED TO MINORS UNLESS LISTED ON THIS SIGNED FORM.

Name of Medication	Dosage	Time To Be Given	How Taken

Comments for First Aid Staff: (Please attach another piece of paper, if more room is needed to list meds or comments.)

MEDICAL RELEASE STATEMENT and EVENT POLICIES & PROCEDURES AGREEEMENT

For Attendees Under the Age of 18:

I, the parent/legal guardian of _____ (attendee), authorize the event first aid personnel to administer the medications listed above. I hereby authorize event personnel to obtain medical care or dental care, if necessary. My signature authorizes emergency treatment in the event of illness/injury when I am not immediately available. I understand, if necessary, the attendee will be taken to a nearby medical facility and will be attended by a physician on call. I further understand that I will be responsible for any medical expenses incurred, and that my medical insurance will be the primary insurance with Oklahoma District Council's insurance being secondary. I also hereby authorize this document to be released to first responders and emergency personnel. I understand that any person with a fever, rash, pink eye, head lice, or other signs of illness will be sent home. I further understand that the parent/legal guardian will be responsible for their child's transportation in the event of an illness or injury. I also agree with and support the enforcement of the event's Policies and Procedures.

Signature of Parent/Legal Guardian _____ Date _____

For Attendees Over the Age of 18:

I, _____ (attendee), authorize the event first aid personnel to administer the medications listed above. I hereby authorize event personnel to obtain medical care or dental care, if necessary. My signature authorizes emergency treatment in the event of illness/injury if I am unconscious or unable to consent to treatment. I understand, if necessary, I will be taken to a nearby medical facility and will be attended by a physician on call. I further understand that I will be responsible for any medical expenses incurred, and that my medical insurance will be the primary insurance with Oklahoma District Council's insurance being secondary. I also hereby authorize this document to be released to first responders and emergency personnel. I understand that any person with a fever, rash, pink eye, head lice, or other signs of illness will be sent home. I further understand that I am responsible for my own transportation in the event of an illness or injury. I also agree with and support the enforcement of the event's Policies and Procedures.

Signature of Attendee _____ Date _____