Christ Church United Methodist

C.R.O.S.S. MINISTRY

Christians Reaching Out Serving our Savior

Participant Information & Medical Form

Name_____ Birth Date_____

Address_____

City_____State_____ Zip_____

Church/Organization_____

Current Medicines Taken_____

Medical Conditions that would effect medical treatment (seizures,ADHD, heart, asthma, etc.)_____

Allergies:_____

Relative/Guardian to contact in case of emergency:

Name_____Relation_____

Phone Numbers: Day_____ Night_____

Medical Insurance Information:

Company:_____ Group #_____

Insured Person's Name_____ ID #_____

Dr.'s Name_____ Phone_____

In the event that emergency medical treatment is required, every effort will be made to contact the responsible persons listed on this form. If this is unsuccessful, consent is given for treatment by competent medical personnel

Signature of participant_____ Date_____

Signature of guardian/parent if participant is under 18

_____Date_____