

The John Wesley United Methodist Church

1927 West Kemper Road
Church Phone: 513-825-0733
Church Fax: 513-825-8090



Cincinnati, OH 45240
Web: <http://www.jwumc.net>

MEDICAL HISTORY AND MEDICAL AUTHORIZATION FORM

Your Information

Participant's Name _____			
Street Address: _____			
City _____	State _____	Zip _____	
Home Phone: _____	Work _____	Cell _____	
Date of Birth: _____	Email Address _____		_____

Your Parent's Information (if you are a minor)

Mother's Name _____		Residence: Primary	Secondary	(Circle One)
Street Address: _____				
City: _____	State _____	Zip _____		_____
Home Phone: _____	Work _____	Cell: _____		
Email Address _____				
Father's Name _____		Residence: Primary	Secondary	(Circle One)
Street Address: _____				
City: _____	State _____	Zip _____		_____
Home Phone: _____	Work _____	Cell: _____		
Email Address _____				

Emergency Contacts (in the event that a parent cannot be reached in an emergency.)

Name _____				
Street Address: _____				
City _____	State _____	Zip _____		_____
Home Phone: _____	Work _____	Cell _____		
Email Address _____				
Relationship to Participant: _____				
Name _____				
Street Address: _____				
City _____	State _____	Zip _____		_____
Home Phone: _____	Work _____	Cell _____		
Email Address _____				
Relationship to Participant: _____				

Your Health Insurance Information

Health Insurance Company _____				
Company Address _____				
City _____	State _____	Zip _____		_____
Claims Phone _____	Policy Number: _____			
Group Number (if applicable) _____				
Primary Care Physician (if applicable) _____				
Primary Care Facility (if applicable) _____				

Please finish other side ----->>>>

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Physician/Medical History/Prescription Information

Physician's Name _____

Street Address: _____

City _____ State _____ Zip _____

Office Phone: _____

Dentist's Name _____

Street Address: _____

City _____ State _____ Zip _____

Office Phone: _____

Indicate the year in which the participant has had or has been diagnosed with the following:

_____ Heart Disease	_____ Diabetes	_____ Chicken Pox
_____ Asthma	_____ Measles	_____ Arthritis
_____ Anxiety Disorder	_____ Clinical Depression	_____ ADD/ADHD
_____ Whooping Cough	_____ High Blood Pressure	_____ Other (_____)

Current Medications and Instructions _____

List Allergies/special needs and any special precautions/treatments that accompany these allergies/special needs:

Dietary Concern/Restrictions: _____

Date of last Tetanus Shot: _____

Parental Authorization

In the event that I cannot be reached in an emergency situation, I give John Wesley UMC or its agents, officers, servants or employees my permission to seek out and transport me/my child to the nearest available source of assistance for emergency medical care. If at all possible, that care should be at _____

Please check

- I give John Wesley UMC or its agents, officers, servants or employees permission to administer over-the-counter medication to me/my child.
- I agree to release any and all photographs or videos taken by JWUMC's representatives during all program events and give my permission for these images to be used in promotional material or on the church web site.

I acknowledge that this is accurate and I will update the information if anything changes.

Signature of Participant (or Parent or Guardian if participant is a minor)

Date

State of Ohio

County of _____

On this, the _____ day of _____, 20____, before me a notary public, the undersigned officer, personally appeared _____, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he executed the same for the purposed therein contained.

In witness hereof, I herunto set my hand and official seal.

Notary Public _____