UMCOR
Global Ministries | The United Methodist Church

MEDICAL RELEASE FORM

Name:			**DOB:**	**M or F:**
Address:			**Home Phone: ( )**	
City:	**State:**	**ZIP:**	**Work Phone: ( )**	
Email:				
Doctor's Name:			**Doctor's Phone: ( )**	
Address:				
City:	**State:**		**ZIP:**	
Current Medication:				
Allergies (*Example: Foods? Medications? Bee/Wasp Stings?)*				
Medical Insurance Company:			**Phone: ( )**	
Insurance Agent:			**Policy #**	
Address:	**City:**		**State:**	**ZIP:**
Please attach copy of insurance card to this release form.				

Signed: _____

Date: _____

*****Complete only if team member is under age 18*****

Parent or Guardian: _____ **Phone:** _____

Address: _____

Street City State ZIP

I hereby give my permission for _____ to be treated by competent medical personnel because of any accident or medical emergency while involved on the UMCOR Sager Brown mission journey.

Signature: _____

Date: _____

Print Name: _____

Relationship to Youth: _____

Revised March 2023