

SAMPLE Medical Release // History Form

Dying Church Rising Hope 2026 Conferences

Registrant

| | | | |
|------------------------------|--------------------------------|---------------------|-----------|
| Child/Dependent's Name _____ | | Date of Birth _____ | |
| Address _____ | City _____ | State _____ | Zip _____ |
| Home Phone _____ | Cell Phone _____ | | |
| Parent/Guardian Name _____ | Email of parent/guardian _____ | | |
| Work Phone _____ | Cell phone _____ | | |
| Physician's Name _____ | Physician's Phone number _____ | | |

Emergency Contact (if listed parent/guardian is unavailable)

| | | |
|---------------|-----------------------------|-------------|
| Name _____ | Relationship to Child _____ | Phone _____ |
| Address _____ | City _____ | State _____ |

Health History

Known Medical Problems: _____

Medications to be taken with directions: _____

Medication Allergies: _____

| | | | | | |
|--------------------|---|---|----------------------|---|---|
| History of Asthma? | Y | N | History of seizures? | Y | N |
|--------------------|---|---|----------------------|---|---|

| | | | |
|----------------------------|---|---|----------------------------------|
| History of heart problems? | Y | N | If yes, nature of problem: _____ |
|----------------------------|---|---|----------------------------------|

| | | |
|----------------------------|--|-------------------------------|
| May be given as necessary: | | Last Tetanus shot (Td): _____ |
|----------------------------|--|-------------------------------|

| | | |
|---------|---|---|
| Tylenol | Y | N |
|---------|---|---|

| | | |
|-----------|---|---|
| Ibuprofen | Y | N |
|-----------|---|---|

Health Insurance Company: _____

Group Number: _____ ID Number: _____

I hereby give my consent in advance to the designated leaders of _____ and to the physicians or hospital selected by them to render emergency treatment as in their judgment is reasonably necessary, including, but not limited to, hospitalization, diagnosis including taking specimens and x-rays, giving blood transfusions and medications, anesthesia and surgery for my dependent listed above. I understand that the leaders of this activity will attempt to contact me before securing medical treatment, but that this consent is given in case I am not available in an emergency.

I specifically release the leadership of this activity from any and all claims, loss, cost, damage or expense arising out of or from any accident or other occurrences causing injury to any person or property.

| | | | |
|------------------------------------|------------|--|------------|
| Signature of Parent/Guardian _____ | Date _____ | Signature of non-related adult witness _____ | Date _____ |
|------------------------------------|------------|--|------------|