



# Alabama Rural Ministry Medical Release Form

Name: \_\_\_\_\_  
(Last) (First) (MI)

Permanent Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_

Mother/ Guardian: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Evening Phone: \_\_\_\_\_  
\_\_\_\_\_

Father/ Guardian: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Evening Phone: \_\_\_\_\_  
\_\_\_\_\_

If my parent is not available, in case of an emergency, please contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

### HEALTH HISTORY: (circle/ give approximate dates)

#### Diseases/ Illnesses:

Asthma _____	German measles _____	Mono _____
Bleeding Disorder _____	Heart Problems _____	Mumps _____
Cancer _____	High Blood Pressure _____	Recurring Strep Infect. _____
Chicken Pox _____	Hypoglycemia _____	Respiratory Problems _____
Diabetes _____	Kidney Problems _____	Other (specify): _____
Ear Infections _____	Knee Problems _____	_____
Eating Disorders _____	Measles _____	_____

#### ALLERGIES:

Hay Fever _____	Ivy Poisoning _____
Insects _____	Other _____

List any previous surgeries or injuries (give dates)

\_\_\_\_\_

Any illness occurring within the past 5 years that caused you to miss school or work for more than 3 days:

\_\_\_\_\_

Drug Allergies: (List any medications you are allergic to):

\_\_\_\_\_

Please list any medical conditions you are currently being treated for:

\_\_\_\_\_

Please list any medications you are currently taking:

\_\_\_\_\_

Have you been out of the USA in the past 9 months? If so, where?

\_\_\_\_\_

In the past 12 months have you been treated for any psychiatric/psychological disorders?

\_\_\_\_\_   
 If yes, please explain:

\_\_\_\_\_

Are you currently being treated for such disorders? Yes \_\_\_\_ No \_\_\_\_

**IMMUNIZATIONS:**

Tetanus- Date of last tetanus \_\_\_\_\_ (please obtain tetanus if you are not current)

I am covered under my parents' Medical Insurance Plan: \_\_ Yes \_\_ No

I have Medical Insurance of my own: \_\_ Yes \_\_ No

Name of Insurance Company: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Policy/Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**CONSENT FOR TREATMENT**

I hereby give permission to the physician selected by \_\_\_\_\_ (group leader) or a member of the ARM staff, to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for myself (or my child). **(Guardian signature required if under 19 years of age)**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date