

Trinity Tower United Methodist Church
Methodist Youth Fellowship
Medical Information

I, _____, give my permission for _____
to receive medical aid by a physician or hospital staff if the need arises during any Trinity
Tower UMYF sponsored event.

Our family health insurance is carried with _____.

Our policy number is _____.

Our primary care physician is _____.

His/Her telephone number is _____.

Date of last Tetanus shot: _____

Please list any known medical problems or allergies:

Please list any physical limitations:

Please list any medications being taken:

Parent/Guardian phone number (home & cell): _____

Emergency contacts (name, relationship, phone number):

I hereby sign that the above information is correct and that I will notify the youth leaders
of any changes throughout the next year so that proper medical attention can be provided.

Parent/Legal Guardian Signature

Date