

**MEDICAL PERMISSION/RELEASE FORM**  
**S.O.S. MINISTRIES, INC.**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Weight: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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INCASE OF EMERGENCY – NOTIFY: \_\_\_\_\_ PHONE: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

FAMILY INSURANCE COMPANY: \_\_\_\_\_ POLICY# \_\_\_\_\_

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**PAST MEDICAL HISTORY**  
**(CIRCLE APPROPRIATE CONDITIONS)**

ASTHMA    KIDNEY TROUBLE    HEART CONDITION    DIABETES

PHYSICAL LIMITATIONS: \_\_\_\_\_

ALLERGIES – FOOD : \_\_\_\_\_ INSECT BITES/STINGS: \_\_\_\_\_

PENICILLIN OR OTHER MEDICATIONS: \_\_\_\_\_

ANY OTHER MEDICAL INFORMATION THAT WOULD BE IMPORTANT FOR THE TEAM LEADER TO KNOW

ABOUT: \_\_\_\_\_

ANY CURRENT MEDICATIONS: \_\_\_\_\_

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**PERMISSION FOR TREATMENT**

I hereby grant permission for, \_\_\_\_\_, to participate in any activities and/or functions that they would normally be involved in between the date of:

Day/Month: \_\_\_\_\_ to Day/Month: \_\_\_\_\_.

My permission is also granted to a responsible leader from or a representative of S.O.S. Ministries to obtain any medical attention that the ministry or medical personnel deem as necessary for the well being of the above name should he or she become ill or injured during the mission.

I/we, the undersigned, do hereby release, remiss and forever discharge all sponsors and S.O.S. Ministries, Clearwater, FL, from any and all claims, demands, actions, or causes of action, past, present, or future arising out of any damage or injury while participating in the mission.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date \_\_\_\_\_

If under the age of 18 years old – Parent/Guardian:

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date \_\_\_\_\_