

**EMERGENCY MEDICAL AUTHORIZATION  
AND  
GENERAL LIABILITY RELEASE**

**ADULT**

**EPWORTH UNITED METHODIST CHURCH  
3077 VALLEYVIEW DRIVE  
TOLEDO, OHIO 43615  
(419) 531-4236**

Purpose: To authorize emergency treatment of adults who become ill or injured while participating in a church-sponsored activity. This form also serves as a consent form releasing Epworth United Methodist Church, its staff, employees and volunteers from any legal or financial liability in the event this participant is injured.

Name of Participant \_\_\_\_\_

Name of Activity \_\_\_\_\_

Site of Activity \_\_\_\_\_

Dates \_\_\_\_\_

Home Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Home (\_\_\_\_) \_\_\_\_\_ Office (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Person to contact in emergency Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home (\_\_\_\_) \_\_\_\_\_ Office (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Date of Tetanus Shot (update if needed) \_\_\_\_\_

Medications \_\_\_\_\_  
\_\_\_\_\_

Allergies \_\_\_\_\_

Other special medical information \_\_\_\_\_  
\_\_\_\_\_

Family Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Health Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Phone (\_\_\_\_) \_\_\_\_\_

**SEE OTHER SIDE FOR SIGNATURES AND NOTARIZATION**

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**REQUIREMENT OF VEHICULAR SEATBELT USAGE**

**STATE LAW REQUIRES THE USE OF SEATBELTS IN VEHICLES. I UNDERSTAND AND AGREE THAT AS A PARTICIPANT AND/OR A PARENT/LEGAL GUARDIAN FOR A PARTICIPANT IN THIS ACTIVITY, IT IS MY/OUR RESPONSIBILITY TO KEEP THE VEHICULAR SEATBELT PROPERLY FASTENED AT ALL TIMES WHILE THE VEHICLE IS MOVING. FURTHERMORE, I/WE ASSUME ALL RESPONSIBILITY AND LIABILITY FOR ANY & ALL INJURIES CAUSED BY THE FAILURE TO KEEP THE VEHICULAR SEATBELT FASTENED AT ALL TIMES.**

**MEDICAL AUTHORIZATION**

IN THE EVENT OF AN EMERGENCY AND AFTER REASONABLE ATTEMPTS TO CONTACT MY SPOUSE OR OTHER RESPONSIBLE PERSON HAVE BEEN UNSUCCESSFUL, I HEREBY GIVE MY CONSENT FOR AN ADULT LEADER TO SIGN FOR EMERGENCY CARE FOR MYSELF AS DEEMED NECESSARY BY A LICENSED PHYSICIAN. I ALSO AUTHORIZE MY TRANSFER TO ANY HOSPITAL THAT IS REASONABLY ACCESSIBLE. THIS AUTHORIZATION DOES NOT COVER SURGERY UNLESS DEEMED NECESSARY BY TWO PHYSICIANS OR DENTISTS PRIOR TO THE PERFORMANCE OF SUCH SURGERY.

**DISCLAIMER OF LIABILITY**

I UNDERSTAND THAT THERE ARE INHERENT DANGERS AND RISKS ASSOCIATED WITH MY PARTICIPATION IN THIS ACTIVITY, IN USING THE FACILITIES AND IN TRAVELING TO AND FROM THE ACTIVITY. I ASSUME THOSE RISKS AND TAKE FULL RESPONSIBILITY FOR ANY INJURIES OR DAMAGES WHICH MAY BE INCURRED DURING THE ACTIVITY, IN USING THE FACILITY AND IN TRAVELING TO AND FROM THE ACTIVITY. I ACCORDINGLY HEREBY FULLY AND FOREVER EXONERATE AND DISCHARGE THE EPWORTH UNITED METHODIST CHURCH, ITS STAFF, EMPLOYEES, VOLUNTEERS AND AGENTS FROM ANY AND ALL CLAIMS, DEMANDS, DAMAGES, RIGHTS OF ACTION OR CAUSES OF ACTION, PRESENT OR FUTURE, WHETHER THE SAME BE KNOWN, ANTICIPATED OR UNANTICIPATED, RESULTING FROM OR ARISING OUT OF MY PARTICIPATION IN THIS ACTIVITY, USING THE FACILITIES AND TRAVELING TO AND FROM THE ACTIVITY. THIS RELEASE BINDS THE UNDERSIGNED AND HIS OR HER SPOUSE, HEIRS, REPRESENTATIVES AND ASSIGNS.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**NOTARIZATION OF MEDICAL AUTHORIZATION AND LIABILITY RELEASE FORM**

STATE OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_, before me personally appeared

\_\_\_\_\_ to me known to be the same person described herein and who executed this instrument, and who acknowledged the same to be the free act and deed thereof.

\_\_\_\_\_  
Notary Public, \_\_\_\_\_ County

State of \_\_\_\_\_

My Commission Expires \_\_\_\_\_