



Medical Release Form

(Please Print)

Church Information:

Church Name: _____ City: _____ State: _____

Leader/Chaperone Information:

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ D/O/B: _____

Primary Phone: (____) _____

Male Female I have attended GO TELL Camps in the past.

Emergency Contact Information:

Emergency Contact #1:

First Name: _____ Last Name: _____

Primary Phone: (____) _____ Relationship: _____

Emergency Contact #2:

First Name: _____ Last Name: _____

Primary Phone: (____) _____ Relationship: _____

Health History Information:

Primary Care Physician Name: _____ Physician Phone: (____) _____

Allergies: Insect Stings Drugs Nuts Poison Ivy
 Other: _____

If you checked any of the conditions for allergies, please give details including normal treatment of allergic reactions: _____

Camper First & Last Name: _____

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Signature (Circle One)

Date