Application and Medical Release Form

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www.MinistriesAtMainStreet.org

Name _____ Date of Birth_____

Address _____

City _____ State _____ Zip _____

Phone # _____ E-mail _____

Gender: ☐ Male ☐ Female

Emergency Contact Person _____

Emergency Contact Phone # _____ Alternate # _____

The applicant is under the care of a physician for the following conditions:

_____

_____

Known allergies (list all, including drug allergies):

_____

Additional information that the staff should be aware of:

_____

_____

Medical Insurance Information

Insurance Company Name _____

Address _____

Group/Plan # _____

If your insurance carrier is an HMO, please provide the name of your physician and phone #:

_____

GUEST'S PLEDGE

I agree to abide by all the policies of the Ministries at MAIN Street, acknowledging that failure to do so will be grounds for dismissal.

Guest's Authorization: This information and health history is correct and complete as far as I know. Staff at the Ministries at MAIN Street Shelter have permission to seek emergency help on my behalf, using this information should the need arise. I hereby give permission to the MAIN Street Staff to seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, billing, or insurance purposes. I give permission to MAIN Street Staff to arrange necessary transportation for myself. I hereby give permission to the physician selected by Health Professionals through MAIN Street Staff to secure and administer treatment, including hospitalization, for me. This complete form may be photocopied for medical purposes.

Guest's Signature _____ Date _____

Staff Signature _____ *Date* _____