Medical Durable Power of Attorney for Health Care

The undersigned, an adult of sound mind, executes this Medical Durable Power of Attorney ("power") pursuant to sections 15-14-503 *et seq.*, of the Colorado Revised Statutes, freely and voluntarily, with an understanding of its purposes and consequences, and hereby grants to the adult leaders of St. Andrew United Methodist Church youth program, designated as agents for this purpose, the power to authorize all medical, dental and hospital care for me and the power to execute all documents and releases necessary to obtain such care, which powers shall not be impaired by my disability, while participating in the St. Andrew UMC activity for which I am registered. I grant the forgoing power for a period ending twelve months from day this Power of Attorney is signed. In consideration of my participation in the activity for which I am registered, I, for myself and for my heirs, legal representatives and assigns, covenant with St. Andrew UMC to never institute any suit or action at law or in equity against St. Andrew UMC, its representatives, assigns, officers, staff or volunteers, for any sickness, injuries or death resulting from participation in the activity. In executing this covenant, I expressly reserve any and all rights, causes of action, claims and demands against any person, entity or association other than St. Andrew UMC, its representatives, officers, staff or volunteers. I give permission for my image to be used in church-related print and web media.

Adult Participant_____(18 and older)

Medical Insurance Company:_____

Name of Insured:_____ Med Insurance Co. Phone_____

Group Name:_____ Policy No._____ Group No._____

DATED this _____day of _____, _____.

Signature _____

_____ _____ _____ _____

Address City State Zip

Home phone: _____ Business phone:_____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Telephone Nos.: _____

STATE OF COLORADO, COUNTY OF_____

The foregoing Medical Durable Power of Attorney for Health Care and covenant not to sue was subscribed and sworn to before me this _____day of _____, _____,

by_____. Witness my hand and official seal.

My commission expires:_____

SEAL _____

Notary Public

MEDICAL INFORMATION

1. Is there a history of chronic infection of nose, throat, ears, sinus or lungs?_____
   If so, describe:
2. Is there a history of heart pathology requiring restricted activity? _____
3. Is this person subject to any skin disease? _____
4. List ALL allergies: (medications, food, plants, animals, bee stings, other, please specify):

   _____
5. Has there been recent illness or exposure to contagious disease?_____
   If so, describe:
6. Is this person subject to fainting, convulsive seizures, nose bleeds, cramps or asthma?_____
   Is he/she diabetic?_____What medication is prescribed for the preceding conditions?_____
7. Limitations of activity:_____
8. Is there any drug or medication to be taken regularly?_____
9. Other recommendations:_____
10. Date of last tetanus shot:_____
11. Participant's doctor, address and phone #_____
12. Participant's Date of Birth_____
    Height_____Weight_____