

**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. Photocopies of this document shall be effective and enforceable as the original, and third parties shall be entitled to rely on photocopies of this document for the full force and effect of all stated terms.

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 \_\_\_\_\_