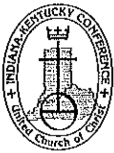

Health Form for Confirmation Retreats

Home Church: ______________________ **Town:** ______________________

Date Attending: ☐ January 25-27, 2008 ☐ February 15-17, 2008 ☐ February 22-24, 2008 (Tower Hill)

Notice of interpretation: This form is to be **signed by the participant (and parent or guardian for youth).** It does not require a doctor's signature. However, if desired or if your child has not had a physical examination in the past 12 months, we suggest that your child have one before coming to camp.

Name: ______________________ ☐ **Youth** ☐ **Adult** **Birth Date:** __________

Address: ____

City: ______________ **State:** ______________ **Zip:** ______________

Home Phone: ______________________ **E-mail:** ______________________

Person to notify in case of emergency if no answer at home or work telephone numbers:

Name: ______________________ Phone #: ______________ Relationship to person: __________

Name: ______________________ Phone #: ______________ Relationship to person: __________

Do you have any allergies, physical restrictions, dietary restrictions or allergies to medications? Yes No

If yes, please describe: ____

Date of last tetanus shot: ______________________________

Are there any physical limitations that would prevent you from participating in any camp activities? Yes No

If yes, please describe: ____

Please list any recent illness: ____

Are you on medication of any kind? Yes No

If yes, please describe: ____

I authorize the camp director or other camp personnel to continue this medication as per instructions.

In the event of an injury, illness or requiring the attention of medical personnel, I agree to permit transportation in private or public vehicles. I/We also give permission under such circumstances to the medical personnel, selected by the Indiana-Kentucky Conference United Church of Christ camp personnel, to order X-rays, routine tests or treatment.

In the event I cannot be reached in an emergency, I hereby give permission to the physician or other health care personnel selected by such camp personnel to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery. I also give permission for my child to be given the following medication as needed: Tylenol, ibuprofen, decongestant, antihistamine or Pepto Bismol. (Cross out any which are not acceptable.)

Insurance Company: ______________________ Policy #: ______________________

Member ID #: ______________________ Member Name: ______________________

Participant Signature: ______________________ Date: __________

Parent/Guardian Signature: ______________________ Date: __________
(if youth)