Weekend/Week Day Health and Permission Form

East Ohio Conference of the United Methodist Church
Camp and Retreat Ministries

Participant's Name _____ Birthday ____/____/____
Mo Day Year

Parent(s) Name(s) (if participant is a minor)_____

Street Address _____Phone (____)_____

City, State, Zip _____

Second Emergency Contact _____ Phone (____) _____

Is the participant covered by family medical/hospital insurance? ___ yes ___ no

If yes, indicate carrier or plan name _____ Group Number _____

Does the participant have any special dietary requirements or food allergies? ___ yes ___ no
If yes, please list.

Does the participant have any allergies? ___ yes ___ no
If yes, please list.

Are any of these allergies life-threatening? ___ yes ___ no
If yes, please note the reaction.

Are there any other health conditions or **special diets** that the leadership should be aware of? ___ yes ___ no
If yes, please explain.

Will the participant bring any medications with them (including inhalers and bee sting kits)? ___ yes ___ no
Please list.

AUTHORIZATIONS:

I am/we are in favor of the above person attending an event and participating in all activities unless otherwise specified. As parent(s), legal guardian(s), or as an adult participant we/I accept the conditions stated, including the release of the Conference and Camp Management/staff from liability in case of accident/injury. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes for the participant named on this health form. IN CASE OF MEDICAL ILLNESS OR INJURY, I hereby give permission to the camp to obtain proper medical care for the participant named on this health form. I authorize the camp nurse or certified first aid care provider to give first aid care, medicine, or treatment as ordered by the camp physician. IN CASE OF MEDICAL EMERGENCY or in the event that the participant needs medical care beyond camp facilities, I/we understand that every effort to reach the parent(s), guardian(s) or secondary emergency contact listed will be made. If no one can be reached, I/we hereby give permission to the attending physician to hospitalize, secure proper treatment for, order injection, anesthesia or surgery as necessary for the participant named on this health form. I authorize the use of photographs or video in promotional materials. (In case of a minor) I give permission for my child to participate in off-site travel, under the supervision of the event leadership, as is part of the program for the event for which she/he is registered.

Signature _____ Date _____