EMERGENCY MEDICAL INFORMATION

NAME: ______________________________ MALE: _____ FEMALE: _______

ADDRESS: ______________________________

GRADE (FALL 2005) ________ AGE ________ PHONE: ______________________________

PARENT'S NAME(S): ______________________________

HOME PHONE: ______________________ WORK OR CELL PHONE(S): ______________________

EMERGENCY AND HEALTH INFORMATION (To be read and completed by parent):

Does youth have*….* (if "yes" - explain)

_____ Yes _____ No ALLERGIES? ______________________________
_____ Yes _____ No HEART CONDITION? ______________________________
_____ Yes _____ No OTHER?

Is youth subject to: (If "yes" – explain)

_____ Yes _____ No FAINTING? ______________________________
_____ Yes _____ No SLEEP WALKING? ______________________________
_____ Yes _____ No UPSET STOMACH? ______________________________
_____ Yes _____ No OTHER?

Does youth have reaction to: (if "yes – explain)

_____ Yes _____ No BEE STING? ______________________________
_____ Yes _____ No PENICILLIN? ______________________________
_____ Yes _____ No OTHER DRUGS? ______________________________
_____ Yes _____ No POISON IVY, OAK, SUMAC? ______________________________
_____ Yes _____ No OTHER?
_____ Yes _____ No Has the youth had any serious illness or surgery within the past ten years?
_____ Yes _____ No Does the youth have any condition that would prevent him/her from participating in any Gathering activities?

Please list

____

____

_____ Yes ____ No Is the youth diabetic?
_____ Yes ____ No Does the youth have any sight or hearing impairment?
_____ Yes ____ No Does the youth wear contact lenses?

Date of last tetanus shot: ______________

Please indicate ANYTHING else that leader should know to help avoid or deal with any situation that might arise:

EMERGENCY INFORMATION: ***MUST BE INCLUDED***

Health Insurance Co. ______________________________ Policy No. ______________________

Name of ANOTHER person to contact: ______________________________ Friend _______ Relative ____

Address: ______________________________
Street City State Zip

Telephone- Home: ______________________ Work: ______________________

Family Doctor's Name: ______________________ Work Phone: ______________________

(over)

AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE

This form should be in the possession of the Gathering participant or Family Group Leader from day of departure to day of return from the Gathering.

(I) (We) the undersigned parent(s) and or legal guardian(s) of ____ ,

a minor (under age 21) do hereby authorize ______________________________, and / or any other adult appointed or designated by him/her) to:

- Consent to medical, surgical and dental care for such minor child,
- Consent to any diagnostic tests, medical, surgical or dental procedure or treatment as my be considered therapeutically necessary by the physician, surgeon, dentist or other health care personnel providing care for such minor child, and
- On (my) (our) behalf, to:
    - Employ physicians, surgeons, dentist, nurses and other health care personnel as my be deemed necessary for such minor child,
    - Admit such minor child to any hospital, clinic, emergency room, laboratory or other health care or diagnostic facility for examination, treatment, surgery or care and
    - Sign all necessary consents and authorizations.

It is understood that this authorization is given in advance of the occurrence of any condition or situation that would necessitate any such medical, surgical or dental care being required, but is given to provide authority to obtain such care if it should be required.

IN WITNESS WHEREOF, I (We) have executed this "Authorization to Consent to Medical and Dental Care" this

____________ day of ___________________, 20____.

____
Parent/Legal Guardian

____
Parent / Legal Guardian

STATE OF)

) SS

COUNTY OF)

On this ________ day of ______________, 20___, before me, a Notary Public, personally appeared and, known to me to be the person(s) who executed the above consent and stated that it was executed as his/her (their) free act and deed.

(SEAL)

____
Notary Public