

Medical Form

(Please fill out all information; use N/A for not applicable.)

Name: _____		Age: _____	
Address: _____		City: _____	
State: _____		Zip: _____	
Parent/Guardian Name (s): _____			
Home phone: () _____		Work phone: () _____	
Cell phone: () _____		E-mail: _____	
Emergency Contact: _____			
Home phone: () _____		Work phone: () _____	
Cell phone: () _____			
Church Name: _____		City: _____	
Chaperone Name(s): _____			

Insurance Information

Is the participant covered by family medical/hospital insurance? ____ Yes ____ No

If so, indicate the carrier or plan name: _____

Group # _____

Family Physician Name: _____ Phone #: _____

Health History

Date of last tetanus shot: _____ Unsure of exact date All immunizations are current

Medication Allergies

Describe reaction and management of the reaction.

Food Allergies – Please list any medical food allergies. If your child has medical dietary needs, please call (814) 234-5824.

Other Allergies – Include insect stings, hay fever, asthma, animal dander, etc.

Medications being taken: _____ This person takes NO MEDICATIONS on a routine basis.

Our Medical Personnel can only dispense medications in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, and the dosage and frequency of administration. Please list ALL medications (including over-the-counter or non-prescription drugs and vitamins) that are taken routinely.

(Form continued on next page)

_____ This person takes medications as follows:	
Med #1: _____	Dosage: _____
Time taken each day: _____	Reason for taking: _____
Med #2: _____	Dosage: _____
Time taken each day: _____	Reason for taking: _____
(If there are more medications, please list them on the back of this form.)	

I give permission for the on-site medical personnel to administer the following medications to my teen when necessary:

____ Tylenol (Acetaminophen) ____ Advil (Ibuprofen) ____ Benadryl (Diphenhydramine)
____ Antacids (Rolaids, tums) ____ Imodium AD ____ Cough drops ____ Decongestants

RESTRICTIONS: The following dietary restrictions apply to this individual.

Does not eat meat. Does not eat eggs. Does not eat dairy products. Other:

Explain any physical restrictions to activities (e.g. what cannot be done, what adaptations or limitations are necessary)
(Please note any swimming limitations as there is a pool at the hotel.)

I hereby give permission for my child to attend worship camp on July 12th through July 14th, 2012. I further certify that this health history is correct as far as I know and the person herein described has permission to engage in all prescribed activities, except as noted. I further agree and consent to have the staff members/chaperones/or any other approved worker under whose auspices the program/activities/events are conducted, to secure any emergency or other medical care or treatment that may be necessary for my child during the entire outing, including travel to and from such event. IN CASE OF EMERGENCY, I hereby give permission to the physician selected by the camp to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child. I understand that the above named insurance will be used for any treatments required.

Heart Exposed Music and host churches are not liable for any injuries or accidents.

Permission is given to Heart Exposed Music to use photographs (individual or group) and/or multimedia images and recordings in the best interest of Heart Exposed Music.

Parent/Guardian Signature

Date