Woods
Memorial Presbyterian Church (USA)

Medical Form
Youth Ministry

Participant's Name: _____

Date of Birth: _____ Age: _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Phone: (_____) _____ - _____

Physician's Name: _____

Physician's Phone: (___)_____-_____ Do you have medical insurance? [ ] yes [ ] no

Please make a copy of your insurance card and attach with form

I/we give our daughter/son permission to receive full medical care in case of an emergency, and I/we assume full responsibility for all medical bills, if any. I give permission to the staff and adult youth leaders of Woods Memorial Presbyterian Church to authorize medical care for my daughter/son and to provide individual transportation to receive care. I/we also agree to hold harmless and indemnify Woods Presbyterian Church, its directors, employees or agents, for any liability by said church as the result of negligent, willful or intentional acts of said participant, including expenses incurred attendant thereto.

NOTE: Prescription drugs, will be held by a designated adult volunteer who will maintain possession of the medication until requested by the youth. It will be the youth's responsibility to self-administer prescription medication. The designated volunteer will exercise discretion when providing youth with required medication.

Participant's Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Current Medications

Medication:	**Medication:**	**Medication**:
Dosage:	Dosage:	Dosage:
Purpose:	Purpose:	Purpose:

Current Allergies

Allergies: _____

Symptoms: _____

Treatment: _____

SERIOUS MEDICAL CONDITIONS

Please note any serious medical conditions our nursing team needs to be aware of prior to the trip.

RECENT SURGERY

Please note any recent surgeries that our nursing team needs to be aware of prior to the trip.

VACCINATIONS

Please check off and write the date of vaccination, where indicated, for all vaccinations.

MMR [ ]	**Tetanus** [ ]	**COVID-19 Vaccine** [ ]
Veracella [ ]	**Polio** [ ]	1st Dose:
DTap [ ]	**Hapatitis B** [ ]	2nd Dose:

HEALTH CONDITIONS

YES	NO	CONDITIONS	MORE INFORMATION
		Abdominal/digestive problems	
		Asthma	Do you carry an inhaler?
		Ankle/Knee/Leg problems	
		Diabetes	Type 1: Type 2:
		Dislocations/Sprains	
		Fainting Spells	
		Heart Disease	
		Hypertension	
		Mental Health Illnesses	If yes, please explain
		Seizures	Last Seizure:
		Sleep Disorders	