

Participant _____

Congregation _____

LWM42



The Gathering

Experience Christ's love and grace

Gathering Health History Form For all participants

Name _____ Gender M F Date of Birth _____
Last First

Home Address _____
Street Address City State Zip

Custodial Parent/Guradian _____ Phone _____

Home Address _____
(If different from above) Street Address City State Zip

Business Address _____ Phone _____
Street Address City State Zip

Second Parent/Guardian _____ Phone _____

Business Address _____ Phone _____
Street Address City State Zip

Person to notify when parent/guardian not available _____

Relationship _____ Phone _____

Address _____
Street Address City State Zip

Insurance Information: Please photocopy the front and back of your health insurance card and attach it to this form.

Carrier or Plan Name _____ Group # _____

The following box must be completed for attendance

This health history is correct and complete as far as I know. I give permission to our youth leader to seek emergency medical treatment. I agree to the release of any records necessary for insurance purposes. I give permission to the camp or youth leader to arrange necessary related transportation for me/my child.

I hereby grant permission for my child, who is under the age of 18, to receive all necessary medical treatment in the case of an emergency. I request and authorize medical personnel, agents, and employees to provide all necessary medical care including but not limited to hospital tests such as pathology, radiology, surgery with anesthesia, and prescription drugs advisable for the health of my child. I acknowledge that no representation, warranties or guarantees as to the results of treatment or cures will be made.

I understand and agree to my child's participation in the Michigan Gathering.

Signature of Parent/Guardian or Adult Camper _____

Printed Name _____ Date _____

Participant _____ Congregation _____ LWM42

Name of family physician _____ Phone _____

Address _____
Street Address City State Zip

Name of Dentist _____ Phone _____

Address _____
Street Address City State Zip

Does the participant have any activity restrictions? (If yes, please explain) _____

Has the participant had any recent illness, injury, or infectious disease? (If yes, please explain) _____

Does the participant have any behavioral, emotional, or mental health problems about which the camp should be aware? _____

Has the participant had the necessary immunizations to attend school? _____ **Please attach photocopy of immunization record.**

Allergies: List all known	Describe reaction
_____	_____
_____	_____

Medications	
_____	_____
_____	_____

Food	
_____	_____
_____	_____

Other Allergies (include insect stings, hay fever asthma, etc.)	
_____	_____
_____	_____

All medications brought by participants must be in the original container and prescriptions must have the participants name on the label from the pharmacy.

Medication	Dose	Frequency	Reason for taking the med.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____