Adult Health Form

A. Adult Contact Information

Name _____ Birth Date _____ Gender_____ Age_____
First M.I. Last

Address_____City_____State_____ZIP_____

Daytime Phone (___)_____ Evening Phone (__)_____

Emergency Contact:

Name_____ Daytime Phone (___)_____ Evening Phone (__)_____ Relationship_____

Name of Physician:_____ Physician's Phone Number:_____

Name of Dentist: _____ Dentist's Phone Number: _____

Insurance Company: _____ Group Number: _____ Policy Number_____

***In case of an emergency, Insurance cards may be difficult to locate at the event. Please attach copy of both sides of insurance card.*

B. Health History

Immunization: Tetanus (Booster) date: _____month/year *required

I have had the following diseases or been immunized for them.

❑ Chicken Pox	❑ German Measles	❑ Measles	❑ Rubella	❑ Hepatitis B
❑ Mumps	❑ Polio	❑ Whooping Cough	❑ Hepatitis A	❑ Hepatitis C

**To protect the health of all who are unable to receive immunizations, we encourage attendees to be vaccinated prior to the start of the event.*

If not fully immunized, please explain: _____

Allergies: ❑ Foods _____ ❑ Medicines _____ ❑ Environmental _____
Insects, pollens, etc.

Conditions:

	❑ Fainting	❑ Frequent Stomach Upset	❑ Diabetic
❑ Asthma	❑ Frequent Colds	❑ Hearing Aid	❑ Dementia
❑ Heart Condition	❑ Glasses/Contacts	❑ Convulsions/Seizures	❑ Other _____

C. Medical Consent Agreement

I hereby consent to The Wisconsin Annual Conference of The United Methodist Church and The Wisconsin Conference Board of Trustees of The United Methodist Church, Inc., and their employees, clinicians, trainers, nurses, or agents, to administer first aid treatment for any minor injuries or illnesses and, if the injury is life threatening or in need of emergency treatment, to seek, approve, and obtain any medical, dental or surgical diagnosis, treatment or care for me including, but not limited to, x-ray, anesthetic, injections, medications, blood transfusions, and hospitalization, which is deemed advisable by, and is to be rendered under the general supervision of a physician, surgeon, dentist, hospital or other medical professional or institution. I authorize the release of any and all medical records concerning the Participant to any healthcare provider authorized to provide care or treatment pursuant to this Medical Consent Agreement. I understand and agree to assume financial responsibility for all expenses of such care. I have read, and I understand, all of the provisions of this Agreement.

Signature _____ Date _____

Please share any medications that would be helpful for us to know about in case of emergency.

*** If you are chaperoning or sharing a cabin with children who are not your own, you must consult the staff for information on safe handling of medications while paticipants are present.*

Medication	Frequency Taken	Dosage

Please list any medical conditions, surgeries, etc. we should be aware of.

_____

_____

_____

_____

I will bring the following to assist with my mobility:

❑ Wheelchair ❑ Cane ❑ Walker ❑ Other _____

Please list any special dietary needs that you have _____

_____

_____

Additionally, to meet my needs it would be helpful for staff to know _____

_____

_____