MEDICAL INFORMATION FORM

(Please fill out this form completely)

Name: ____

Age:____ Birth Date: _________ Gender:_______

Address: ____ City: _______ State: ___ Zip: _________

EMERGENCY CONTACT

Name: ____

Home Phone: (___)__________________ Cell Phone:_________________

Relationship to Chaperone: ____

MEDICAL INFORMATION

****Please include a copy of both sides of your insurance card!!****

(If any information changes before convention, please be sure to let us know.)

Family Doctor: _____________________ Doctor's Phone: _______________

Insurance Company: __________________________Phone #: _______________

Insurance Company Address: ______________________________________

Group #: ______________ Policy #: ______________________

Insured Policy Holder's Name Adult)___________________________

ALLERGIES-LIST ALL KNOWN

Medical Allergies____

Food Allergies____

Other medical conditions (diabetes, high blood pressure, etc.) the medical team should be aware of:

____

____

____

WAIVER

I waive all claims against Georgetown Protestant Reformed Church and the Lake Williamson Christian Center, or one of their representatives, for any injury or illness which may result directly or indirectly from my participation. I further state that I am in the proper physical condition to participate.

Signature: _________________________________ Date: __________