

Medical Information, Waiver, and Release of Liability

Date _____

Conventioneer Information

First, Middle, and Last Name _____

Age on Monday, August 10, 2020: _____ Birth Date: _____

Address: _____ City: _____

State/Province/Country: _____

Primary Phone Number: _____

Parent/Guardian Information

Name(s): _____

Home Phone; _____ Cell Phone: _____

Additional Contact Name (aunt/sister/grandparent/etc.) _____

_____ Relationship to Conventioneer: _____

Phone Number: _____

Medical Information

Doctor's Name: _____

Doctor's Phone Number: _____

Insurance Company: _____

Group Number: _____ Policy Number: _____

Insured Policy Holder's Name (Adult): _____

Insurance Co. Address: _____

Insurance Co. Phone Number: _____

Allergy/Health Information

*Please know that we take all allergy and medical information very seriously. Our goal is to accommodate everyone's individual needs.

Medical Allergies: _____

Food Allergies: _____

Other Allergies: _____

Special Needs/Physical or Medical (please explain) _____

Medical Conditions: _____

Date of last Tetanus Vaccine: _____

List any medications that are being taken. (dose/frequency/any comments) All prescriptions must be in original containers.

Does your child need help taking their medications? _____ Yes _____ No

If yes, list medications that need to be administered by the medical staff and any specific instructions below.

Please use this space for any additional information regarding allergies or medical conditions.

When mailing, please include a copy of the front and the back of your insurance card.

Did you include this? _____ Yes _____ No

Please direct any Medical/Health/Allergy questions or concerns to **Kevin Timmerman** at registration@prcconvention.com

Emergency Medical Treatment Authorization

HIPAA Release and Indemnification Form

By signing this form below, I hereby declare that I am the biological parent or legal guardian of:

Minor's Full Name: _____

Minor's Date of Birth (MM/DD/YYYY): _____

I authorize Lake Williamson Conference and Retreat Center and Georgetown Protestant Reformed Church, or one of their representatives to consent on my behalf to any and all medical treatment, transportation, and /or medical care for the illness or injury of the above-mentioned minor August 10-14, 2020. This does not impose a duty upon Camp Michindoh, SWPR, PPRC, or their representatives to provide such treatment, transportation, or care.

I also authorize Lake Williamson Conference and Retreat Center and Georgetown Protestant Reformed Church, or their representatives, to permit the release of this minor's medical records to a healthcare provider of their choice. This is in compliance with HIPAA Privacy Rules.

I understand that there are certain dangers and risks inherent in the activities, programs, and games made available to the minor by Lake Williamson Conference and Retreat Center and Georgetown Protestant Reformed Church, up to and including permanent disability or death. While Lake Williamson Conference and Retreat Center and Georgetown Protestant Reformed Church, and their representatives will take reasonable precautions to prevent this, I agree to indemnify and hold harmless Lake Williamson Conference and Retreat Center and Georgetown Protestant Reformed Church, and their representatives for any injury to person and/or damage to/loss of property.

Signature of parent / legal guardian: _____

Date of Signature (MM/DD/YYYY): _____

Printed Name and Address of person who signed above: _____
