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. Also, CPR card if certified. ****

If any information changes before convention, please be sure to let us know - Thanks!

Family Doctor: _____ Doctor's Phone: (_____)_____

Insurance Company: _____ Ins. Phone: (_____)_____

Insurance Company Address:_____

Group #:_____ Policy #: _____

Insured Policy Holder's Named Adult: _____

ALLERGIES-LIST ALL KNOWN

Medical Allergies_____

Food Allergies_____

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

_____

_____

_____

_____

WAIVER

I waive all claims against Faith Protestant Reformed Church, Crossings Camps, or Cedarmore Camp 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: _____