

ADULT MEDICAL FORM

The following information is required for all adult participants. Information is confidential and will be made available only to those adults who are directly responsible for the participant's care. *For their safety and well-being, no participant will be allowed to be part of the event without a completed and **signed** Medical Authorization and History Form.*

Participant's Name: _____

Please list any allergies: _____

Taking any medications: Yes No Please list: _____

Is the participant under the direct care of a physician? Yes No

Please explain: _____

Any medical conditions that the camp should be aware of: _____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

Name _____ Relationship _____

Home Phone () _____ Work Phone () _____

RELEASE STATEMENT

I, _____ the undersigned, do hereby authorize the adult leaders acting on behalf of the California-Nevada Annual Conference of The United Methodist Church, as agent, and working with other non profit agencies to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s), especially in case of emergency, to give specific consent to any such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his or her judgment may deem advisable. I agree to pay for any medical, dental, surgical, or hospital diagnosis, treatment, or care rendered to me.

Adult Signature

Date