Mid-Ohio Valley Work Camp: Medical Release Form

Name:_____ Congregation:_____

Home Address: _____

Gender: □ Male □ Female Birthdate: _____

Custodial Parent/Guardian: _____

Address: _____

Home Phone: _____ Work:_____ Cell: _____

Second Emergency Contact: _____ Phone:_____

Relationship: _____

Insurance Information:

Is the Participant covered by medical/hospital Insurance? □ Yes □ No

Group # _____ Carrier or Plan Name:_____

Allergies or Medical Conditions/surgeries: (List all known, including Food, and medical management if any):

_____ _____

_____ _____

Medications Taken: Please list ALL medications (including nonprescription drugs) taken routinely and what they are for. Bring enough medication for this event. Keep it in the original packaging/bottle that identifies the physician/name of medication/dosage and frequency taken. (Administration of medication is the responsibility of the individual or Chaperone of their group unless arranged in advance.)

_____ _____

_____ _____

By signing, I give my child permission to hold and administer his/her own medications. As a guardian, I am responsible for my child's medication administration.

Parent's Signature: _____

I hereby give my approval and consent to this application and therefore relieve any sponsoring congregation or Work Camp staff member from any and all liability for sickness, accidents, or injuries of any nature or cause whatsoever, while attending, traveling to or from Work Camp. I further give authorization for the camp directors or any approved camp personnel to administer such acts of first aid as seem necessary, and to transport the camper to a doctor or emergency room to secure the services of a licensed physician. I further promise to utilize family insurance for any major medical care requiring hospitalization. (You must have family insurance).

_____ _____

Signature of Parent or Guardian (if under 18) ***Signature (if over 18)***

Date_____