

Health Record Form – CYLS 2009

Participant's Name: _____ Gender: _____ Date of Birth: ___/___/___

Contact Person's Name: _____ Relation to Camper: _____

Contact Person's Telephone: Home (____) _____ Cell (____) _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

INSURANCE COMPANY: _____

Policy # _____ Group # _____

Participant's I.D. or Social Security #: _____

OTHER INSURANCE INFORMATION: _____

Give dates and types of operations/accidents within the last two years:

Check all that apply:

<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Chronic Infection	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Allergies
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Sleeping Disorders	<input type="checkbox"/> Hernia	<input type="checkbox"/> Asthma
<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Fainting	<input type="checkbox"/> Convulsion
<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Poison Ivy/Oak	<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Migraines
<input type="checkbox"/> Recent Illness	<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Hearing Difficulty	<input type="checkbox"/> Glasses
<input type="checkbox"/> Recent Exposure to a Contagious Disease		<input type="checkbox"/> Reaction to Insect Bites	

If YES to any of the above, please explain: (You can attach additional pages, if needed.)

IMMUNIZATION HISTORY (Please give date of immunization or last booster)

DTP _____ OR Diphtheria _____ Tetanus _____ Polio _____

MMR _____ OR Measles _____ Mumps _____ Rubella _____

Hepatitis A _____ Hepatitis B _____ Varicella (Chicken Pox) _____

Date of last health exam: _____ Were any complicating problems noted? _____

Has the participant ever required psychiatric counseling (including depression), hospitalization or medication? If yes, please specify:

Detail any Physical, Mental or Emotional Limitations:

ALL MEDICATIONS (prescriptions and over-the-counter) MUST BE turned in to the Camp Nurse at registration. They MUST be in the ORIGINAL CONTAINER with original label and all instructions attached. If participant is using multiple medications, please put Medication Vials in a Ziploc Bag with the Name written on it in Magic Marker.

Is this participant taking any form of medication? ___ YES ___ NO

List all drugs and dosages:

Authorizations & Releases - CYLS 2009

PARTICIPANT'S NAME: _____

May the medical staff of Lake Brownwood Christian Retreat/the Directors of this event from the Christian Church in the Southwest give your child Tylenol, Benadryl, and/or topical solutions to treat them for minor aches, pains, and ailments as they should be evident? All medications will be administered in accordance with manufacturer's directions and/or with the physician on call.

YES NO Parent's Signature: _____

Name of Family Physician: _____ Phone #: _____

Name of Dentist: _____ Phone #: _____

Name of Orthodontist: _____ Phone #: _____

While the Christian Church (Disciples of Christ) in the Southwest and Lake Brownwood Christian Retreat make every effort to provide a safe and pleasant environment for all participants, we require that this participation agreement be read, completed, signed, and dated by the parent or legal guardian of each participant under 18 years of age who wishes to participate in the Christian Youth Leadership Seminar.

LIABILITY RELEASE

In consideration for my child's/ my participation in activities sponsored by the Christian Church (Disciples of Christ) in the Southwest (CCSW), **the undersigned, for myself and my child (the participant named above), hereby release and forever discharge the CCSW and all persons associated with the CCSW, from any and all actions, causes of action, claims and demands, known and unknown, which my child may now have or may have in the future on account of or arising out of my child's/my participation in these activities.** I acknowledge that the CCSW may provide accident insurance for participants, and that any and all expenses occurring 1) beyond the maximum benefits of the policy, or 2) as a result of actions that result in the exclusion of this policy, will be paid for by the undersigned. This waiver of liability is binding on the undersigned and on all persons claiming through the undersigned or said child, and the heirs, and personal representatives of the undersigned and said child. I give my permission for my child to ride in any vehicle designated by the director of the event while participating in activities sponsored by the Christian Church (Disciples of Christ) in the Southwest. I have read, understood, and consented to all parts of this Liability Release.

AUTHORIZATION FOR MEDICAL CARE:

I give permission for my child, the above-named participant, to participate in activities sponsored by the Christian Church (Disciples of Christ) in the Southwest (CCSW). I authorize an adult, in whose care the minor has been entrusted, to consent to any X-ray examination or medical or dental treatment to be rendered to the minor on the advice of any physician or dentist, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. (Every attempt will be made to contact parents in the event of an emergency when permission for treatment is necessary.) I agree to indemnify the CCSW against any claim in connection with medical and dental services rendered to my child. Should it be necessary for my child to return home due to medical reasons or otherwise, I shall assume all transportation costs. I give permission for my child to ride in any vehicle designated by the Director of the Christian Youth Leadership Seminar while seeking medical care or treatment.

Signed at _____ this _____ day of _____, 2009.

PARENT'S SIGNATURE: _____

For more information, please call the Regional Office at (817) 926-4687 or contact your Area Minister.