

**California-Nevada Annual Conference  
The United Methodist Church  
FAMILY CAMP MEDICAL AUTHORIZATION AND MEDICAL HISTORY**

Should there be a medical emergency, this information will be used by trained medical personnel. Information is confidential and will only be used if a serious medical situation arises.

<b>Name of Participants: (First and Last)</b>	<b>Gender</b>		<b>Birth date</b>
1. _____	Male	Female	_____
2. _____	Male	Female	_____
3. _____	Male	Female	_____
4. _____	Male	Female	_____
5. _____	Male	Female	_____
6. _____	Male	Female	_____

**Primary Contact Information:**

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Local Church: \_\_\_\_\_

**In case of an emergency, please contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

**Insurance Information:**

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Insurance Carrier/Plan Name: \_\_\_\_\_ Policy ID #: \_\_\_\_\_  
Carrier Address: \_\_\_\_\_

Are any family members Vegetarian: Yes No How many? \_\_\_\_\_

Are any of the participants under the direct care of a physician?

(Please indicate participant's number(s) 1-6) \_\_\_\_\_

Please Explain:

Are there any other medical conditions or allergies we should know about? Yes No

(Please indicate participant's number(s) 1-6) \_\_\_\_\_

Please Explain:

Are any of the participants taking medication while participating at camp?

(Please indicate participant's Number(s) 1-6) \_\_\_\_\_

Please Explain:

## Emergency Consent form

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(s) for the undersigned and family members listed on this form, 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.

Print Name: \_\_\_\_\_

Signature : \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Family: \_\_\_\_\_