

# Harrisonville UMC Next Generations Ministries

## PARTICIPANT/HEALTH FORM

(Please Print)

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ M / F

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Parent / Guardian (s) Name \_\_\_\_\_

Address (if different from student) \_\_\_\_\_

Home phone \_\_\_\_\_ Work #: (M) \_\_\_\_\_ (F) \_\_\_\_\_

Cell phones \_\_\_\_\_ (M) \_\_\_\_\_ (F) \_\_\_\_\_

Alternate emergency contact: Name \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance information: **Include a copy of the health insurance card**

Name of company \_\_\_\_\_

Policy number \_\_\_\_\_ Group number \_\_\_\_\_

In whose name is the insurance \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Health History:

Medical conditions we need to know: \_\_\_\_\_

Allergies/Reactions: \_\_\_\_\_

Present Medications: \_\_\_\_\_

*(Please attach a medication schedule for any events where staff will distribute medications)*

Any additional information staff needs to know regards to participant: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Wear glasses /contacts? Yes No

Date of last tetanus shot \_\_\_\_\_

*Please Continue on Reverse Side*

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Initials:

\_\_\_\_\_ I understand that in the event medical interventions is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I (we) cannot be reached, I give my permission for medical treatment to the physician or dentist selected by the adult leaders of the United Methodist Church.

\_\_\_\_\_ I understand that my insurance coverage will be used as primary coverage in the event a medical emergency occurs.

\_\_\_\_\_ I give permission for my student to be transported in the church van and/or personal vehicles operated by Harrisonville United Methodist Church staff/volunteers.

\_\_\_\_\_ I understand all reasonable safety precautions will be taken at all times by the church and its agents during the events and activities. I agree not to hold the church leaders, employees and volunteer staff liable for damages, losses, diseases, or injuries incurred.

\_\_\_\_\_ For publicity and promotional purposes, I will allow my youth's picture to be taken and used in print and/or media outlets for HUMC.

Parent(s) Signature: \_\_\_\_\_

Date of signature: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

HUMC Adult Witness \_\_\_\_\_ Date \_\_\_\_\_