YOUTH PARTICIPANT MEDICAL CONTACT INFORMATION

Must be completed by all participants.
Must be signed by parent or guardian of participants under 21.
Please type or print legibly in ink!

PARTICIPANT NAME: (Last) ______________________________ (First) ______________________________

BIRTH DATE: _____/_____/_______ MALE:______ FEMALE:______

ADDRESS:____ __________________

CITY/STATE/ZIP: ____

HOME PHONE: ( ) _________________________ DAY PHONE: ( )__________________________

CUSTODIAL PARENT/GUARDIAN: ____

HOME PHONE: ( ) _________________________ DAY PHONE: ( )__________________________

HOME ADDRESS (IF DIFFERENT) ____

HEALTH PLAN CARRIER: ____

NAME OF INSURED:____

RELATIONSHIP TO PARTICIPANT: ____

POLICY HOLDER OR INSURANCE ID NUMBER: ____

FAMILY DOCTOR:____

OFFICE PHONE: ( )_________________________ MEDICAL EXCHANGE: ( ) __________________

FAMILY DENTIST: ____________________________ OFFICE PHONE: ( )_______________________

SECOND PARENT OR EMERGENCY CONTACT PERSON: _________________________________

RELATIONSHIP TO PARTICIPANT: ____

HOME PHONE: ( ) _________________________ DAY PHONE: ( ) __________________________

Please specify if any health insurance pre-certification, notification, or other requirements exist for the participant: ____

Medical Card Copy Front

Medical Card Copy Back

AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE

Must be completed by parents or guardians of participants under 21 years old.

(I) (We), the undersigned parent(s) and/or natural guardian(s) of ______________________________, a minor, do hereby authorize my child's youth leader (and/or any other adult appointed or designated) to (i) consent to medical, surgical and dental care for such minor child, (ii) consent to any diagnostic tests, medical, surgical or dental procedure or treatment as may be considered therapeutically necessary by the physician, surgeon, dentist or other health care personnel providing care for such minor child, and (iii) on (my) (our) behalf, to (a) employ physicians, surgeons, dentists, nurses, and other health care personnel as may be deemed necessary for such minor child, (b) admit such minor child to any hospital, clinic, emergency room, laboratory or other health care or diagnostic facility for examination, treatment, surgery or care and (c) sign all necessary consents and authorizations. It is understood that this authorization is given in advance of the occurrence of any condition or situation which would necessitate any such medical, surgical or dental care being required but is given to provide authority to obtain such care if it should be required. I fully understand the consequences of the foregoing statements and sign this AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE knowingly, freely and willingly.

This authorization shall continue for such time as my child is participating in Youth Activities and during travel to and from the youth activity.

MEDICAL CONSENT AND LIABILITY AND ACTIVITY RELEASE FORM

Must be completed by all participants or by parents/guardians of participants under age 21.

I understand that Pilgrim Youth Activities for which this MEDICAL CONSENT AND LIABILITY AND ACTIVITY RELEASE FORM is being given is described as: See attached sheet on location and activities

I hereby consent to participation of myself (or of my child) in Pilgrim Youth Activities. I have read the attached sheet regarding the planned activities.

I understand that I have a duty to provide primary accident and medical insurance for myself (or for my child) and I declare that I am (or my child is) covered by primary accident and medical insurance.

I release and forever discharge, Concordia University, and the Lutheran Churches and Agencies which will serve as youth activity locations and their agents and servants, successors and assigns, directors, trustees, officers, employees, and other representatives from any and all , damages and causes of action either at law or in equity that I may have as a result of my (or my child's) participate in, attendance at, and travel to and from the activity. Furthermore, I do hereby expressly stipulate, and agree to indemnify and hold harmless Concordia University and the Lutheran churches and agencies, its agents and servants, successors and assigns, directors, trustees, officers, employees, and other representatives against loss from any and all present or future claims, demands, or actions in law or in equity that may hereafter be made or brought by me or my child, by anyone on behalf of me or my child, or by anyone else on their own behalf for damages or any other legal or, equitable remedy on account of any injury, illness, physical condition, inconvenience or loss sustained by me or my child during the Pilgrim Youth Activity or travel to and from it.

I hereby acknowledge that I have read this consent, understand its contents, and have signed it on my own free act and deed.

______________________________	______________	____________________________
Participant Signature	Date	Witness

or

______________________________	______________	____________________________
Parent/Guardian Signature (if participant is under 21)	Date	Witness

EMERGENCY MEDICAL INFORMATION FORM

Please complete so that health providers can be aware of your personal health needs.
Must be completed by all youth participants.

Name of Participant: ____

Does participant have: (if "yes" explain)

____Yes ____No ALLERGIES?
____Yes ____No HEART CONDITION? ______________________________
____Yes ____No OTHER? ______________________________

Is participant subject to: (If "yes" explain)

____Yes ____No HEADACHES? ______________________________
____Yes ____No SEIZURES? ______________________________
____Yes ____No MOTION SICKNESS? ______________________________
____Yes ____No FAINTING? ______________________________
____Yes ____No SLEEP WALKING?______________________________
____Yes ____No UPSET STOMACH? ______________________________
____Yes ____No OTHER? ______________________________

Does participant have reaction to: (If "yes" explain)

____Yes ____No BEE STING? ______________________________
____Yes ____No PENICILLIN?______________________________
____Yes ____No OTHER DRUGS? ______________________________
____Yes ____No POISON IVY, OAK, SUMAC?______________________________
____Yes ____No OTHER? ______________________________

____Yes ____No Has the participant had any serious illness or surgery within the past ten years?
Please list: ______________________________

- Yes ______________________________ ____
Please list: ______________________________

____Yes ____No Does the participant take any prescription medication?
Please list: ______________________________
____Yes ____No Are any drugs ineffective in treatment? ______________________________
____Yes ____No Is the participant diabetic? Medication?______________________________
____Yes ____No Does the participant have any sight or hearing impairment?______________________________
____Yes ____No Does the participant wear contact lenses? ______________________________
____Yes ____No Does the participant wear hearing aids?______________________________

Blood type: ______________________ Date of last tetanus shot: ______________________

A current tetanus shot is required. After 7 years, another tetanus shot is recommended.

Please indicate ANYTHING else that leaders should know to help avoid or deal with any medical situation that might arise: ______________________________