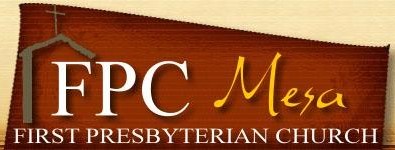
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**2017 - 2018 Wednesday WRAP**

***Adult* Mandatory Health & Consent Form**

**Block 1: \_\_\_\_\_\_\_\_ Pd: \_\_\_\_\_\_\_\_**

**Block 2: \_\_\_\_\_\_\_\_ Pd: \_\_\_\_\_\_\_\_**

**Block 3: \_\_\_\_\_\_\_\_ Pd: \_\_\_\_\_\_\_\_**

**Block 4: \_\_\_\_\_\_\_\_ Pd: \_\_\_\_\_\_\_\_**

1. Name of Participant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Name of Participant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Person**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Do you have health insurance? \_\_\_\_\_\_\_ Name of insurance company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in whose name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History**

Any pre-existing medical conditions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any allergies? \_\_\_\_\_\_\_\_To medications?\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dietary Restrictions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_ Epilepsy/Nervous Disorders \_\_\_\_\_ Heart Condition \_\_\_\_\_ Insect Stings \_\_\_\_

Asthma \_\_\_\_\_Physical Handicap \_\_\_\_\_\_\_

Any major illnesses during the past year?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Medical and Liability Release Statement:

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the even I cannot be reached in an emergency during the activity dates shown on this form, I hereby give permission to the physician or dentist selected by the activity leader to hospitalize, to secure medical treatment and/or order an injection, anesthesia, or surgery to myself, as deemed necessary.

I understand all reasonable safety precautions will be taken at all times by the First Presbyterian Church of Mesa (FPC) and its agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold FPC, its leaders, employees and volunteer staff liable for damages, losses, diseases or injuries incurred by the subject of this form.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

**Consent**

In the event of illness or injury, I give permission for any medical treatment for myself deemed necessary for my health and safety. I certify that the medical information contained on this form is complete and correct to the best of my knowledge. I also give consent for myself to be photographed during FPC activities and for those photos to be used in church publications, websites/webpages.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_