MEDICAL CONSENT FORM – Youth Participant

*Once completed, please make a copy of this form for EACH participant.
(Keep one with the Family Group Leader and keep one with the participant)

Name: _____
(Last) (First) (Middle Initial)

Mailing Address: _____
(Street) (City) (State) (Zip)

Male: _____ Female: _____ Age: _____ Date of Birth: _____(*MM/DD/YEAR*)

Parent's Name(s) (if under age 21): _____

Parent's Phone - Home (_____)_____ Cell 1(_____)_____ Cell 2(_____)_____

HEALTH INFORMATION: To be completed by ALL Participants

Please explain special diet and health arrangement needs (including allergies, heart conditions, medical needs, etc):

_____

Does the participant have any current/ongoing medical conditions? ____Yes ____No
If yes, please list: _____

Do you have any condition that would prevent you from participating in any activities? ____Yes ____No
Please list: _____

Have you had any serious illness or surgery within the past ten years? ____Yes ____No
Please list: _____

Are you diabetic? ____Yes ____No **Date of last Tetanus shot**:_____

Do you give permission for nursing staff to administer over-the-counter medication? (check one): ____Yes ____No

Does the participant have any medical allergies? ____Yes ____No
If yes, please list: _____

Please list **ANYTHING** else the leaders should know to help avoid or deal with any situation that might arise:

_____

INSURANCE INFORMATION: MUST BE INCLUDED

Health Insurance Co.:_____ Policy No.: _____
Name of policy holder: _____
Name of another person to contact: _____Friend/Relative
Address:_____
(Street) (City) (State) (Zip)
Telephone: Home (_____)_____ Work (_____)_____
Family Doctor's Name:_____ Work Phone (_____)_____
Family Dentist's Name:_____ Work Phone (_____)_____
Do any pre-certification, notification, or other requirements exist with respect to the participant's health insurance? _____ If so, specify_____

AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE / PERMISSION TO ATTEND

For participants under 21 years old:

☐ I/We, the undersigned parent(s) and/or natural guardian(s) of _____, a minor, do hereby authorize my/our child's youth leader to arrange for such medical, dental, or hospital treatment as deemed advisable for the health and well-being of the above named minor during the Nebraska District Middle School Youth Gathering.

☐ I/We understand that an attempt will be made to notify the parent(s)/guardian(s) first. However, if parent(s)/guardian(s) are not available, or if the need for medical attention is immediate, the above authorization will be used. I/We understand that this authorization is given in advance of the occurrence of any condition or situation that would necessitate any such medical, surgical, or dental care, but is given to provide authority to obtain such care if it should be required.

☐ I/We give permission for my/our child to attend and fully participate in the Nebraska District Middle School Youth Gathering.

☐ I/We understand the consequences of the foregoing statements and sign this **MEDICAL CONSENT FORM** knowingly, freely, and willingly.

Signature: _____ Date:_____
(parent/guardian signature)

Witness: _____ Date:_____
(Primary Adult Leader or Pastor signature)