

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 District 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 2026 District Youth Gathering—Kearney.

☐ 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)