

**PROSPECT UMYM HEALTH FORM**

This form must be completed by the parent/guardian.

PARTICIPANT \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_  
PARENT/GUARDIAN \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

**IF NOT AVAILABLE FOR AN EMERGENCY, NOTIFY:**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_  
NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

**INSURANCE INFORMATION**

INSURANCE COMPANY: \_\_\_\_\_ ID NUMBER \_\_\_\_\_  
INSURANCE ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
NAME OF POLICY HOLDER \_\_\_\_\_ Social Security \_\_\_\_\_

**IMPORTANT: NO PARTICIPANT UNDER 18 YEARS OF AGE WILL BE ALLOWED TO PARTICIPATE UNLESS THIS BOX IS FULLY COMPLETED.**

**AUTHORIZATION FOR MEDICAL TREATMENT**

The undersigned parent/guardian/person authorizes the UMYM Director of the Prospect United Methodist Church or one of it's agents to secure medical treatment for \_\_\_\_\_ in case of any illness or accident for which the UMYM Director or first aid personnel feels professional medical attention is required. I hereby give permission to the physician selected to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for me/my child as named.

\_\_\_\_\_  
*Signature of Parent/Guardian or Participant if of legal age*                      *Relationship*                      *Date*

I understand that the above signature authorizes the UMYM of Prospect United Methodist Church acting through its appointed Coordinator to secure medical treatment for me.

\_\_\_\_\_  
*UMYM Participant Signature*                      *Date*

Family Physician \_\_\_\_\_ Number \_\_\_\_\_

**HEALTH INFORMATION**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Allergies \_\_\_\_\_

Eyes- ( )Normal ( )Glasses ( )Contacts Ears -( )Normal( )Hearing Aid ( )Hard of Hearing

Medications (Please list all prescribed and over the counter) \_\_\_\_\_  
\_\_\_\_\_

Are you sending the medication \_\_\_\_\_ Date of last Tetanus booster \_\_\_\_\_

Specific Medical History \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Special Diet \_\_\_\_\_