

# minimikes!

St. Michael's Conference West Coast 2010

All the spiritual transformation of the St. Michael's Conference packed into one swift punch



## Medical Release and Wavier of Liability

Male  Female Age \_\_\_\_\_ Grade in School \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name (First & Last) \_\_\_\_\_

FATHER'S NAME (First & Last) \_\_\_\_\_

MOTHER'S NAME (First & Last) \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Other Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
First and Last Name

### MEDICAL INFORMATION

Family Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_ Policy and/or Group: \_\_\_\_\_

### Medical Information past or present (please check):

Asthma	<input type="checkbox"/> yes	<input type="checkbox"/> no	ADD/ADHD	<input type="checkbox"/> yes	<input type="checkbox"/> no
Heart Defect/Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no	Head Lice (recent)	<input type="checkbox"/> yes	<input type="checkbox"/> no
Sleepwalking	<input type="checkbox"/> yes	<input type="checkbox"/> no	Chicken Pox	<input type="checkbox"/> yes	<input type="checkbox"/> no
Tuberculosis	<input type="checkbox"/> yes	<input type="checkbox"/> no	German measles	<input type="checkbox"/> yes	<input type="checkbox"/> no
Seizures	<input type="checkbox"/> yes	<input type="checkbox"/> no	Measles	<input type="checkbox"/> yes	<input type="checkbox"/> no
Diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no			

Other Diseases or Conditions yes no \_\_\_\_\_

Currently under Dr's Care yes no Recent Hospitalization yes no

For each checked yes, please explain: \_\_\_\_\_

### Allergies

Hay Fever	<input type="checkbox"/> yes	<input type="checkbox"/> no	Bee Stings	<input type="checkbox"/> yes	<input type="checkbox"/> no	Penicillin	<input type="checkbox"/> yes	<input type="checkbox"/> no
Oak/Ivy Poisoning	<input type="checkbox"/> yes	<input type="checkbox"/> no	Bee Sting Kit?	<input type="checkbox"/> yes	<input type="checkbox"/> no	Other drugs	<input type="checkbox"/> yes	<input type="checkbox"/> no
Foods	<input type="checkbox"/> yes	<input type="checkbox"/> no	Other insect or animals	<input type="checkbox"/> yes	<input type="checkbox"/> no			

Other allergies? \_\_\_\_\_

Current Medications to be continued at camp/event (dosage/frequency) \_\_\_\_\_

Most Recent Tetanus Shot \_\_\_\_/\_\_\_\_/\_\_\_\_

Dietary Restrictions yes no \_\_\_\_\_

Any reason to restrict full activity including long hikes, strenuous physical games? Yes No

If yes, please explain: \_\_\_\_\_

### Non-Prescription Medications: I authorize the following or the generic equivalent to be administered as needed:

Tylenol	<input type="checkbox"/> yes	<input type="checkbox"/> no	Chloraseptic	<input type="checkbox"/> yes	<input type="checkbox"/> no	Pepto Bismol	<input type="checkbox"/> yes	<input type="checkbox"/> no	Benadryl	<input type="checkbox"/> yes	<input type="checkbox"/> no
Ibuprofen	<input type="checkbox"/> yes	<input type="checkbox"/> no	Cough drops	<input type="checkbox"/> yes	<input type="checkbox"/> no	Cold medicine	<input type="checkbox"/> yes	<input type="checkbox"/> no	Cough Syrup	<input type="checkbox"/> yes	<input type="checkbox"/> no

**APPLICANT (18 YEARS OR OLDER) or PARENT/GUARDIAN MUST SIGN WAIVER BELOW**

**Episcopal Diocese of San Diego Medical Release and Waiver of Liability**

**I hereby release the Episcopal Diocese of San Diego, and St. Michael's by-the-Sea Episcopal Church, its directors, officers, employees and volunteers from responsibility and liability for any injury or illness that my youth/young adult, OR I as an adult participant may sustain during this activity. In the event of an emergency, I hereby authorize an adult leader of this activity, as agent for me, to consent to any x-ray examination, medical, dental or surgical diagnosis, treatment and hospital care advised and supervised by a physician, surgeon, or dentist (as appropriate), licensed to practice under the laws of the state where the services are rendered, either at a doctor's office or in any hospital. I expect to be contacted as soon as possible. The medical information stated above is true and accurate to the best of my knowledge and belief.**

✱ Signature of Parent or Guardian, or Adult Participant

\_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_