Indiana-Kentucky Conference, United Church of Christ (IKC)
1100 W 42nd Street, Suite 155, Indianapolis, IN 46208 (317)924-1395

Health Form

This health form must be turned in to attend the event.
Please attach a copy of health insurance card.

Name of Event: _____ Dates of Event: _____

Notice of interpretation: This form is to be completed and signed **(by parent or guardian if youth)**. If participant has not had a physical in the past 12 months, we suggest having one before the event.

Name: _____ M F Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of adult youth lives with: _____ Relationship to youth: _____

Home Phone: _____ E-Mail: _____

Alternate phone numbers:

Father/Guardian Name: _____ Home #: _____ Work #: _____

Mother/Guardian Name: _____ Home #: _____ Work #: _____

Person to notify in case of emergency if no answer at home or work telephone number:

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

How will youth be transported to/from the retreat? Youth Group Parent/Guardian Driving Self Other: _____

Chaperone's Name: _____ Chaperone Attending? Yes No

Minister Youth Leader Other: _____

1. List allergies, dietary restrictions or allergies to medications: _____
2. Date of last tetanus shot: _____
3. List current medications: _____
4. Are there any physical limitations that would prevent participation in any event activities? Yes No

   If yes, please describe: _____
5. Please list any recent illness: _____
6. I authorize the IKC/event staff to administer current medication as per instructions. I also give permission for the following medication as needed: antacid, antihistamine, decongestant, acetaminophen, aspirin or ibuprofen**.** (Cross out any not acceptable.)

In the event of an injury or illness requiring medical attention I hereby give permission for the IKC/event staff to provide: medical care; emergency transportation; physician; and purchase prescribed medications. I give permission to the medical personnel to provide treatment, routine tests and order X-rays. In the event I cannot be reached, I give permission to the physician/health care personnel to hospitalize; secure proper treatment; provide injections, anesthesia and/or surgery.

I understand that this is a privilege for me to attend this retreat. I will participate fully and cooperate knowing that others are concerned for my safety. If I have a problem, I will find an adult I trust and ask for help. I am aware that pictures from events are exchanged and also used for publicity.

Participant's Name (Printed): _____

Participant Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

For youth under 18 or 18 and in high school

Health Insurance Co _____
Policy # _____ ID# _____
Claims Address: _____
City _____ State _____ Zip _____
Phone #

IKC is secondary to your personal insurance:

Claim #_____