

2009 FM BIBLE QUIZ FINALS

Roberts Wesleyan College – July 6-10, 2009

Individual Medical Form

Full Name: _____ Gender: Male ___ Female ___

Church's Name And City: _____ Home Telephone: _____

Date Of Birth ___/___/___ Current Age: _____

Health History (give approximate dates):

_____ frequent ear infections	_____ mononucleosis	_____ hay fever
_____ heart defects/disease	_____ chicken pox	_____ ivy poisonings
_____ bleeding/clotting prob.	_____ rubella	_____ insect stings
_____ convulsions	_____ measles	_____ Penicillin
_____ diabetes	_____ mumps	_____ asthma
_____ Hypertension	_____ sexually trans. disease	_____ drug reactions

When "yes" is checked below, please give complete explanation (on additional paper if needed).

Proper information is essential!

1. Operations/injuries that impair activities? YES ___ NO ___
2. Chronic/recurring illnesses? YES ___ NO ___
3. Activities limited by physician? YES ___ NO ___
4. Medications currently being taken? YES ___ NO ___
5. Any reactions/allergies to foods or medications? YES ___ NO ___
6. Any abuse/addiction to alcohol/drugs of any kind? YES ___ NO ___

Immunizations: Give month/year (Required information!)

_____ diphtheria (DPT or TD)	_____ measles	_____ mumps
_____ tetanus (DPT, TD or tetanus)	_____ polio	_____ rubella

Family Health Insurance INFORMATION (must be completed):

Doctor's name _____ Phone _____

Name of Health Insurance Company _____

Policy and/or Group Number _____

Our medical insurance will cover treatment at the event site in an emergency situation. ___ YES ___ NO

Name of insurance company agent _____ Phone _____

PLEASE READ CAREFULLY AND SIGN THIS PERMISSION/RELEASE FORM:

This information is correct and up-to-date to the best of my knowledge. The above named person has permission to engage in all the planned activities of this Bible Quiz program sponsored by the Free Methodist Church of North America, and I agree not to hold the Free Methodist Church, Bible Quizzing, or any agent of the Church (including **Roberts Wesleyan College**) liable or responsible for actions of or damages caused by myself or the above named person. EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel selected by the event director or supervision adult to order X-rays, routine tests, and treatment for my child if I cannot be reached in an emergency. I also give permission to the emergency physician to hospitalize, secure treatment, and order injection/anesthesia/surgery for the above named person. This form may be photocopied for use off-site.

Parent/Guardian _____
(please print legibly)

Parent/Guardian _____ Date _____
(signature)