Lott Carey – A Global Christian Missional Community
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HEALTH HISTORY FORM

A completed Health History Form is required for all Youth Seminar Participants.
A parent's signature is required for youth ages 14-17. All applicable sections **MUST** be completed.
ALL information provided will remain CONFIDENTIAL

PERSONAL DATA		
Name (last, first, middle initial):		**Telephone** (cell phone):
Address (street address, city, state, zip code):		
THIS SECTION MUST BE COMPLETED FOR YOUTH AGES 14-17		
Father's Name:	Home/Cell Telephone:	Work Telephone:
Mother's Name:	Home/Cell Telephone:	Work Telephone:
THIS SECTION MUST BE COMPLETED FOR PERSONS 18 AND OLDER.		
Spouse's Name (if married):	Home Telephone:	Work Telephone:
Legal Guardian (if not married):	Home Telephone:	Work Telephone:

INSURANCE INFORMATION		
Name of Policy Holder:		
Name of Insurance Carrier:	Policy No.	Telephone:
Physician's Name:	Physician's Telephone:	
Dentist's Name	Dentist's Telephone:	

EMERGENCY CONTACT INFORMATION In the event of an emergency, please list two people who may be called.		
Name:	Telephone:	Relationship:
Name:	Telephone:	Relationship:
Signature of Seminar Participant **OR** Legal Guardian:		Date:

TO BE COMPLETED BY PHYSICIAN OR MEDICAL PROVIDER				
Patient's Name (last, first, middle initial):				
Patient's Address (street address, city, state, zip code):				
Date of Birth:	Age:	Height:	Weight:	Sex:

Date of Last Physical Exam (Month/Day/Year):	Date of Last Tetanus Shot (Month/Day/Year)
Immunizations up-to-date?	If not, please explain:

Please check (√) **YES** or **NO** in response to the following questions:	YES	NO
1. Were there any complicating medical problems noted in patient's last health examination?		
2. Is patiently currently under a physician's care for a medical problem?		
3. Does patient currently have medication prescribed by a physician to be taken on a regular basis?		
4. Will prescribed medications be in chaperone's possession?		
5. Since patient's last health examination, has patient had a serious injury requiring medical attention?		
6. Since patient's last health exam, has patient had an illness lasting longer than one week?		
7. Is patient restricted from participating in **<u>any</u>** type of physical activity?		
8. Is patient currently taking **<u>any</u>** type of over-the-counter medications that may affect his/her participation in Youth Seminar activities?		

IF YOU ANSWERED "YES" TO ANY QUESTION (1-7) ABOVE, PLEASE EXPLAIN.

ALLERGIES (Check ALL that apply):		OTHER HEALTH CONDITIONS:	
	Medicines/Drugs		Special Dietary Regimen
	Asthma		Nose Bleeds
	Hay Fever		Menstrual Cramps
	Other (specify)		Emotional Disturbances (specify)
	Other (specify)		Hearing Impairment
	Other (specify)		Other (specify)

LIST PERTINENT MEDICAL HISTORY OR CHRONIC MEDICAL CONDITIONS THAT MAY REQUIRE IMMEDIATE ATTENTION:

Signature of Physician or Medical Provider:	Date:

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

TO WHOM IT MAY CONCERN:

Subject to the conditions set forth below, my signature below hereby represents consent for _____ (attendee's name) to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to _____ (attendee name) participation in the **66th Annual Youth Seminar of Lott Carey, June 22 - June 27, 2024.**

Should a medical emergency arise during _____'s (attendee's name) participation in the **66th Annual Youth Seminar of Lott Carey, June 22 - June 27 2024,** I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers provided. If it is believed that _____'s (attendee's name) life or health may be adversely affected by the delay that an attempt to contact a parent, spouse, legal guardian and/or designated alternate would cause, I consent to:

➲ **The administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility identified below or chosen by the youth leader and/or Lott Carey;**

Preferred Medical Facility:_____

➲ **The contacting of the local emergency medical response team for emergency medical treatment and/or transport to a medical care facility; and**

➲ **The immediate administration of life-sustaining measures deemed necessary under the circumstances.**

_____
Signature of Participant

_____
Legal Guardian (ages 14-17 ONLY)(PLEASE PRINT)

_____
Signature of Legal Guardian (ages 14-17 ONLY)

NOTARY: