MEDICAL INFORMATION and CONSENT FORM

(Please print legibly)

Date _______________

Name______________________________________ **Home Congregation** _______________________________

Parent/Guardian ____

DOB _______________ **Age** _______________ **Sex:** ☐ ***Male*** ☐ ***Female***

Social Security Number __________________________________

Personal Physician _________________________________ **Telephone** (____) ____________________

I. HEALTH EXAM

To Licensed Medical Practitioner:

The minor individual named above desires to participate as a Volunteer for WOW (St. John's Lutheran Church and all mission partners associated with WOW) and engage in the activities related to being a Volunteer. The Volunteer understands that the activities may become physically stressful and or dangerous and include cleaning, building or construction work, working with children and the elderly, being transported in vehicles to and from work site locations and related group activities, and includes consuming food and living in accommodations set up by the WOW ministry program.

Please indicate:

____ Approved for participation in all activities

____ Specify any exceptions:

_____ Recommendations (explain any restrictions or liabilities):

Signed: _____________________________________ Date: __________________ M.D./ D.O./ D.C./P.A./R.N.P.

Licensed Medication Practitioner Circle One

Name ____ **Date** ___________________

II. MEDICAL PERMISSION

If I have a medical emergency during my WOW Week, please contact the following family member:

Name ____ Relationship: ____

Day Phone ____________________ Night Phone ______________________ Other Phone ______________________

In case the above person is not available, please contact the following:

Name _________________________________ Phone ____________________ Other Phone ______________________

Name _________________________________ Phone ____________________ Other Phone ______________________

III. AUTHORIZATION TO OBTAIN MEDICAL TREATMENT FOR A MINOR

As parent/legal guardian of ____, a minor, I do hereby authorize and give permission to Pastor Amy Figg, the WOW medical volunteer, or any adult chaperone designated by St. John's Lutheran Church to seek and obtain any medical services that in their judgment my child may need while participating in WOW. It is my understanding that I will be contacted as soon as possible, but not necessarily prior to emergency treatment that might be medically required in the opinion of the medical care provider.

I further understand and agree that I will be responsible for any such incurred medical costs.

____

Signature of parent/guardian Date

IV. NON EMERGENCY MEDICAL TREATMENT

My initials below indicate that I agree that my child may receive the following non-emergency medical treatment from any adult affiliated with St. John's Lutheran Church, as deemed appropriate by said adult volunteer.

_____ Acetminophen (e.g. Tylenol)
_____ Ibuprofin (e.g. Motrin)
_____ Naproxen Sodium (e.g. Aleve)
_____ Antihistamines (e.g. Benadryl)
_____ Decongestant (e.g. Sudafed)
_____ Sore throat spray (e.g. Chloraseptic)
_____ Cough lozenges (e.g. Halls Cough Drops)
_____ Cough medicine (non-narcotic, e.g. Delsym)
_____ Antacids (e.g. Malox)
_____ Anti-diarrhea medication (e.g. Imodium)
_____ Basic, non-invasive, First Aid (e.g. disinfecting cream, topical ointment, sunburn lotion, etc.)

V. INSURANCE INFORMATION

Medical Insurance Company ____

Policy #____

Group #____