

OTM TEC
MEDICAL PERMISSION FORM
(Please print legibly)

Date _____

Name _____ Home Congregation _____

Parent/Guardian _____

DOB _____ Age _____ Sex *Male Female*

Social Security Number _____

Personal Physician _____ Telephone (____) _____

Please explain any "yes" answers:

1. Have you ever been hospitalized? Yes No
2. Are you presently taking any medications or pills (including vitamins, inhalers, OTC meds)? Yes No
3. Do you have any allergies (medications, foods, bees, stinging insects)? Yes No
4. Have you ever passed out during exercise? Yes No
5. Do you have any skin problems (itching, rashes)? Yes No
6. Have you ever had a head injury? Yes No
7. Have you ever been knocked out or unconscious? Yes No
8. Have you ever had a seizure? Yes No
9. Have you ever had heat or muscle cramps? Yes No
10. Have you had problems with your eyes or vision? Yes No
11. Have you ever sprained, dislocated, fractured, broken or had repeated swelling of any bones or joints? Yes No
12. Have you had a medical problem since your last evaluation? Yes No
13. When was your last tetanus shot? _____
14. Have you ever had chicken pox? Yes No If no, have you received the vaccine? Yes No
15. When was your last physical exam? _____

16. Do you have any chronic medical conditions (i.e.:asthma, diabetes, depression, anxiety)?

17. Do you have any dietary restrictions?

18. How would you describe your present state of health?

19. Is there any specific information you would like us to know?

I hereby state that, to the best of my knowledge, the above answers are correct.

Signature of youth

Signature of parent/guardian

Date

*Thank you for this information. It will remain confidential
with our medical volunteer and will be destroyed after your OTM TEC retreat.*

Youth Name _____

I

If I have a medical emergency during the retreat, please contact the following family member:

Name _____ Phone _____ Other Phone _____

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

Name _____ Phone _____ Other Phone _____

Name _____ Phone _____ Other Phone _____

II

AUTHORIZATION TO OBTAIN MEDICAL TREATMENT FOR A MINOR

As parent/legal guardian of _____, a minor, I do hereby authorize and give permission to the Pastor Amy Figg, the medical volunteer or an adult chaperone with OTM TEC to seek and obtain any medical services that in their judgment my child may need while participating in OTM TEC. It is my understanding that I will be contacted as soon as possible, but not necessarily prior to treatment that might be emergent.

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

Signature of parent/guardian

Date

III

My initials below indicate my child may receive the following non-emergency medical treatment from any adult affiliated with OTM TEC, as deemed appropriate:

- _____ Acetaminophen (e.g. Tylenol)
- _____ Ibuprofen (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-diarrheal medication (e.g. Imodium)
- _____ Basic First Aid (e.g. disinfecting cream, topical ointment, sunburn lotion, etc.)

IV

Medical Insurance Company _____

Policy # _____

Group # _____