OKLAHOMA
ASSEMBLIES OF GOD

EVENT: _____

Office Use Only	
Meds	
Holds	

MEDICAL FORM

This form is required for all attendees.

Church City: _____ Church Name: _____

Attendee First Name: _____ Middle Name: _____ Last Name: _____

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

Gender *(Select One)*:	Date of Birth *(mm/dd/yyyy)*:	Age:	If student, 2022-2023 Grade:
_____	_____	_____	_____

Emergency Contact Information:

Primary Contact: _____ Relationship: _____

Cell Phone: _____ Additional Contact Number: _____

Second Contact: _____ Relationship: _____

Cell Phone: _____ Additional Contact Number: _____

Medical Information:

Medical Insurance Provider: _____

Policy Number: _____ Group Number: _____

Physician's Name: _____ Phone: _____

List all allergies/medical conditions and any special considerations of which we should be aware:

May the attendee listed above be given over-the-counter, non-prescription medications or applications, not to exceed recommended dosage for stomach discomfort, burns, cuts, insect bites, rash, scrapes, or other minor ailments? *(Select One)*

Yes No

PLEASE READ AND INITIAL BESIDE EACH STATEMENT:

_____ ALL MEDICATION MUST BE IN THEIR ORIGINAL CONTAINERS WITH A CURRENT/CORRECT LABEL.

_____ Pills sent in plastic baggies or weekly dose containers will not be given.

_____ Expired medication will not be given.

_____ All inhalers, nasal sprays, and epi-pens must be in the original box with the prescription label. (If the box is not available, ask the pharmacy to print a label.)

_____ All medication, vitamins, supplements, and oils must be stored in the First Aid Station.

_____ All medication, vitamins, supplements, and oils must be administered by the First Aid Staff in the First Aid Station.

_____ **NO MEDICATION, VITAMINS, SUPPLEMENTS, OR OILS WILL BE ADMINISTERED TO MINORS UNLESS LISTED ON THIS SIGNED FORM.**

_____ If the parent/guardian lists a dosage for medication that is **different** from the doctor's prescribed dosage listed on the bottle, the listed dosage will be administered, and the parent/guardian will assume all responsibility for the changes.

WILL THIS CAMPER/COACH BE BRINGING MEDICATION, VITAMINS, SUPPLEMENTS, AND/OR OILS TO CAMP?

Name of Medication	Dosage	Time to be Given	How Taken

DO YOU HAVE ANY COMMENTS FOR FIRST AID STAFF?

MEDICAL RELEASE STATEMENT AND EVENT POLICIES & PROCEDURES AGREEEMENT

FOR ATTENDEES UNDER THE AGE OF 18:

I, the parent/legal guardian of _____ (attendee), authorize the event first aid personnel to administer the medications listed above. I hereby authorize event personnel to obtain medical care or dental care, if necessary. My signature authorizes emergency treatment in the event of illness/injury when I am not immediately available. I understand, if necessary, the attendee will be taken to a nearby medical facility and will be attended by a physician on call. I further understand that I will be responsible for any medical expenses incurred, and that my medical insurance will be the primary insurance with Oklahoma District Council's insurance being secondary. I also hereby authorize this document to be released to first responders and emergency personnel. I understand that any person with a fever, rash, pink eye, head lice, or other signs of illness will be sent home. I further understand that the parent/legal guardian will be responsible for their child's transportation in the event of an illness or injury. I also agree with and support the enforcement of the event's Policies and Procedures.

Signature of Parent/Legal Guardian _____ Date _____

FOR ATTENDEES OVER THE AGE OF 18:

I, _____ (attendee), authorize the event first aid personnel to administer the medications listed above. I hereby authorize event personnel to obtain medical care or dental care, if necessary. My signature authorizes emergency treatment in the event of illness/injury if I am unconscious or unable to consent to treatment. I understand, if necessary, I will be taken to a nearby medical facility and will be attended by a physician on call. I further understand that I will be responsible for any medical expenses incurred, and that my medical insurance will be the primary insurance with Oklahoma District Council's insurance being secondary. I also hereby authorize this document to be released to first responders and emergency personnel. I understand that any person with a fever, rash, pink eye, head lice, or other signs of illness will be sent home. I further understand that I am responsible for my own transportation in the event of an illness or injury. I also agree with and support the enforcement of the event's Policies and Procedures.

Signature of Attendee _____ Date _____