**MWPCY MEDICAL EMERGENCY FORM**

MWPCY Retreat Participant's Name:

_____

Parents' Names: _____

Home Address: _____

City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

**INSURANCE INFORMATION**

Insurance company:

_____

Insurance #:

_____

Group (if any):

_____

**Responsible adult to contact in emergency if parents not available:**

Name: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Work Phone:_____

**HEALTH HISTORY**

Allergies? _____

Prescribed medication? _____

Date of last tetanus shot: _____

Chronic illnesses? _____

Special dietary needs/concerns?

_____

In the event that I cannot be reached in an emergency, I hereby give my permission to the physician or surgeon or dentist to hospitalize, to secure proper treatment and/or order an injection, anesthesia, or surgery for my child as deemed necessary. I understand that every effort will be made to contact parents first if there is an accident involving my child.

**Parent's signature**: _____ **Date:** _____

**PLEASE ALSO SEND A PHOTOCOPY (BOTH SIDES) OF YOUR INSURANCE CARD.**