

N.W.M.C. HEALTH FORM FOR ADULTS

Type or Print – If typed, it can be saved and **e-mailed** to the conference office – office@nwmcmmission.org. If e-mailed initials will be accepted in signature line. It can also be mailed to the conference office, **or** it can be brought to registration

NAME: _____
Last First Middle

Birth Date: _____ Sex: _____

Parent, guardian, or emergency contact person:

Name: _____

Address: _____
Street City/State Zip

Telephone: **Must complete one** H: _____ Cell: _____ W: _____

Personal Physician's Name: _____

Physician's Address: _____

Physicians: Telephone: _____

MEDICAL HISTORY

YES NO

Has this person ever had a hospitalization, surgery, or serious medical illness? Explain:

Is this person currently under the care of a physician? Explain:

Has any physician ever recommended that there should be any limitations placed on participation in competitive physical activities? Explain:

Has this person ever blacked out or lost consciousness during physical activity? Explain:

Does this person wear contacts or glasses?

List allergies to medications:

List all current medications:

All registrants and/or their parents/guardians understand that the New Wilmington Mission Conference does not assume responsibility for illness, accidents or other expenses incurred as the result of any normal course of the delegates' participation in the programs of the Conference. Expenses resulting from illness or accidents are the responsibility of delegates or their parents/guardians. I have carefully read the Conference regulations in the brochure and am able to participate in the entire Conference program.

Delegate's signature

Date

INSURANCE INFORMATION

Name of Insurance Company: _____

Address: _____

I.D. and Policy No. _____

Name of Insured: _____

S.S. # _____

Delegate's relationship to insured: _____

AUTHORIZATION FOR EMERGENCY MEDICAL/SURGICAL TREATMENT

The authorization granted herein will be used **ONLY** when absolutely necessary. It will be used only after every attempt has been made to contact the parent/guardian.

AUTHORIZATION:

In case of emergency, I hereby authorize the doctor/hospital to which (delegate's name) _____ may be brought (and whomever they may designate as their assistants) to perform any emergency procedure, to give treatment and the administration of anesthetics, or to provide counseling services when needed.

Signed: _____

Date: _____