## Mid-Ohio Valley Work Camp: Medical Release Form

Name:		Congregation:
Home Address:		
Gender: □ Male	□ Female	Birthdate:
Custodial Parent/Guardian: _		
Address:		
Home Phone:	Work:	Cell:
Second Emergency Contact:		Phone:
Relationship:		
<b>Insurance Information:</b>		
Is the Participant covered by	medical/hospital Ins	urance?
Group #		Carrier or Plan Name:
Allergies or Medical Condition if any):	ons/surgeries: (List a	all known, including Food, and medical management
	permission to hold a	and administer his/her own medications. As a
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Parent's Signature:		
congregation or Work Camp injuries of any nature or cau further give authorization for acts of first aid as seem necessecure the services of a licent	staff member from se whatsoever, whil r the camp directors ssary, and to transpo sed physician. I furt	plication and therefore relieve any sponsoring any and all liability for sickness, accidents, or e attending, traveling to or from Work Camp. I or any approved camp personnel to administer such ort the camper to a doctor or emergency room to her promise to utilize family insurance for any ou must have family insurance).
	n (if under 18)	Signature (if over 18)