MEDICAL INFORMATION AND CONSENT

This form must be completed and emailed to wmforms@mbcb.org

Select Event: ☐ Mississippi Baptist All-State Youth Choir & Orchestra ☐ HeartSong ☐ Summer Music & Arts Camp for Kids (SMACK)

Participant Name_____ Date of Birth _____ Age _____ Gender _____

Grade Last Completed: _____ Parent/Guardian Names _____ Church _____

Address _____
P O Box or Street City State Zip Code

Medical Insurance Company _____ Policy # _____

PLEASE INCLUDE A SCAN OF BOTH SIDES OF THE INSURANCE CARD. IF YOU DO NOT HAVE MEDICAL INSURANCE, ENTER "NONE" ABOVE.

EMERGENCY CONTACTS

Primary _____ Relationship _____ Cell # _____ Home/Work # _____

Alternate #1 _____ Relationship _____ Cell # _____ Home/Work # _____

Alternate #2 _____ Relationship _____ Cell # _____ Home/Work # _____

HEALTH HISTORY Do you currently have or have you ever been treated for any of the following?

YES	NO	CONDITION	DETAILS OF CONDITION AND CURRENT TREATMENT
		Contacts/Glasses	
		Legally Blind	
		Removable Dental Appliances	
		Ear/Eyes/Nose/Sinus problems	
		Migraines/Frequent Headaches	
		Head Injury or Concussion	
		Nosebleeds	
		Fainting Spells/Dizziness/POTS	
		Seizures/Epilepsy	
		Other neurological problems	
		Thyroid problems	
		High Blood Pressure	
		Adult or congenital heart disease/heart attack/chest pain (angina)/coronary artery disease/heart murmur. Any heart surgery or procedure. Explain all 'yes' answers.	
		Stroke/TIA	
		Asthma	
		Obstructive Sleep Apnea/Sleep Disorders	
		Other Lung/Respiratory Problems	
		Diabetes	
		Celiac Disease	
		Chron's Disease	
		Gastric Esophageal Reflux Disease	
		Irritable Bowel Syndrome	
		Motion Sickness	
		Other Abdominal/Stomach/Digestive Problems	
		Kidney or Urinary Tract Problems	
		Blood Disorders/Sickle Cell Disease	
		Muscle or Bone Issues	
		Anxiety/Panic Attacks	
		Depression	
		Other Psychiatric/Psychological/Emotional Difficulties	
		List all surgeries and hospitalizations	
		Any other medical conditions not covered above	
		List any physical restrictions we should be familiar with	
		Chicken Pox or Varicella Vaccine?	Date of last Vaccine:
		Measle/Mumps/Rubella or Vaccine?	Date of last Vaccine:
		Tetanus Vaccine?	Date of last Vaccine:

Name_____ **Date of Birth**_____

ALLERGIES

Are you allergic to or do you have any adverse reaction to any of the following? Please explain any reaction and treatment.

YES	NO	ALLERGIES / REACTIONS	EXPLAIN
		Medication	
		Food	
		Environmental (animal, smoke, mold, etc.)	
		Insect bites/stings	

MEDICATIONS

List all medications currently used, including any over-the-counter medications. If additional space is needed, please indicate on a separate sheet and attach.

☐ **NO MEDICATIONS ARE ROUTINELY TAKEN**

MEDICATION	DOSE	FREQUENCY	REASON

INFORMED CONSENT, RELEASE AGREEMENT, AND AUTHORIZATION

I give permission to chaperones from the church listed above and Mississippi Baptist Convention Board (MBCB) event staff to administer first aid and over-the-counter medications as needed. If a medical emergency should arise while participating in this Mississippi Baptist Convention Board sponsored event, and the emergency contacts cannot be reached; I hereby give permission to the church chaperone or MBCB event staff to select a physician and/or hospital for care. I also give the hospital and/or physician my permission to hospitalize, treat and administer medication to meet any emergency medical needs. I further authorize release of provided medical information to appropriate medical personnel and/or the health insurance company if I am unable to do so. I will assume primary responsibility for any medical bills.

Parent/Guardian _____ _____
Signature Date

_____
Printed Name

Witness _____ _____
Signature Date

_____
Printed Name

Place Front of Insurance Card Here	Back of Insurance Card Here

Scan and e-mail this form to wmforms@mbcb.org