MEDICAL INFORMATION and CONSENT FORM

Date _______________ **WOW Week:**_______________

Name_______________________________________ **Church/Group Name**_______________________

Parent/Guardian____

DOB _______________ **Age** _______________ **Sex:** __ **Male** __ **Female**

Social Security Number __________________________________

Personal Physician _________________________________ **Telephone** (____) ____________________

Physician's Group or Practice ____

I. HEALTH EXAM To be filled out by Physician. (May substitute with most recent physica**l).**
To Licensed Medical Practitioner:

The minor individual named above desires to participate as a Volunteer for WOW (Win Our World Inc and all mission partners) and engage in the activities related to being a Volunteer. The Volunteer understands that the activities may become physically stressful and or dangerous and include cleaning, building or construction work, working with children and the elderly, being transported in vehicles to and from work site locations and related group activities, and includes consuming food and living in accommodations set up by the Win Our World Inc Summer ministry program.

Please indicate:

____ Approved for participation in all activities

____ Specify any exceptions:

_____ Recommendations (explain any restrictions or liabilities):

Printed Name:____

Signed: _____________________________________ **Date:** __________________
M.D./ D.O./ D.C./P.A./R.N.P.
Licensed Medication Practitioner Circle One

II. EMERGENCY CONTACTS

If I have a medical emergency during my WOW Week, please contact the following family member:

Name____ **Relationship:** ________________________

Primary Phone _________________________ **Secondary Phone** ______________________________

In case the above person is not available, please contact the following:

Name________________________ **Phone** _____________________ **Other Phone** ________________________

Name________________________ **Phone** _____________________ **Other Phone** ________________________

III. AUTHORIZATION TO OBTAIN MEDICAL TREATMENT FOR A MINOR

As parent/legal guardian of ____, a minor, I do hereby authorize and give permission to the WOW medical volunteer, or any adult chaperone designated by Win Our World Inc, to seek and obtain any medical services that in their judgment my child may need while participating in WOW. It is my understanding that I will be contacted as soon as possible, but not necessarily prior to emergency treatment that might be medically required in the opinion of the medical care provider.

I further understand and agree that I will be responsible for any such incurred medical costs.

____ _____________________________

Signature of parent/guardian **Date**

IV. NON EMERGENCY MEDICAL TREATMENT

My initials below indicate that I agree that my child **may receive** the following non-emergency medical treatment from any adult affiliated with Win Our World Inc, as deemed appropriate by the Executive Director or designated appointee.

_____ Acetminophen (e.g. Tylenol)

_____ Ibuprofin (e.g. Motrin)

_____ Naproxen Sodium (e.g. Aleve)

_____ Antihistamines (e.g. Benadryl)

_____ Decongestant (e.g. Sudafed)

_____ Sore throat spray (e.g. Chloraseptic)

_____ Cough lozenges (e.g. Halls Cough Drops)

_____ Cough medicine (non-narcotic, e.g. Delsym)

_____ Antacids (e.g. Malox)

_____ Anti-diarrhea medication (e.g. Imodium)

_____ Basic, non-invasive, First Aid (e.g. disinfecting cream, topical ointment, sunburn lotion, etc.)

Please describe known allergies: ____

____

Please include other important information: ____

____

V. INSURANCE INFORMATION

Medical Insurance Company ____

Policy #____

Group #____

Please include a copy of your Medical Insurance Card if possible.