

YOUTH (for adult form see next page)

MEDICAL RELEASE FORM and INSURANCE INFORMATION

Youth Events – Presbytery of West Virginia

To be signed by parent or guardian for each young person participating in the Presbytery of West Virginia’s FALL YOUTH RETREAT on NOV. 15-17, 2024. Please send it with your youth to the event.

I give permission for my child, _____,
to participate in the FALL YOUTH RETREAT of the Presbytery of WV, Nov. 15-17, 2024 at
Bluestone Camp & Retreat. In case of emergency, I give my permission for medical treatment.
Please reach me at one of the following telephone number:

Day _____ Night _____. In the event I cannot be reached in the case of
an emergency, please contact: _____

who is _____(relationship to youth)

at phone number: day _____ night _____.

Signature of Parent _____

Print Name _____

Address: _____

**INSURANCE INFORMATION: This needs to be completed each time. Please do not
assume the presbytery has this on file. This form will be shredded after the event.**

Company: _____

Address: _____

Policy Number: _____ Name of insured _____

Address: _____

Current Medications: _____

Allergies _____

Surgeries: _____

Special Needs, dietary or otherwise _____

Please circle if your child has a history with any of these medical problems:

Hay Fever

Convulsions

Lung Problems

Bee stings

Blood Pressure Problems

Ulcers

Fainting

Cancer

Kidney Problems

Asthma

Heart Disease

Diabetes

Sulfa Drug Allergic Reaction

Poison Ivy or Oak

Penicillin Allergic Reaction

Other Illnesses or Conditions: _____

Anything else the leaders of this event should know about your youth?

Name _____

ADULTS

MEDICAL RELEASE FORM and INSURANCE INFORMATION
Youth Events – Presbytery of West Virginia

To be completed by each Adult participant at the Presbytery of West Virginia FALL YOUTH RETREAT on NOV. 15-17, 2024. PLEASE COMPLETE BEFORE YOU ARRIVE AND BRING WITH YOU.

While we hope to never have to use this information, in the event that something happens such that you are unable to provide this, you are asked to complete the following.

INSURANCE INFORMATION: This needs to be completed each time. Please do not assume the presbytery has this on file anywhere. This will be shredded after the event.

Company: _____

Address: _____

Policy Number: _____ Name of insured _____

Address: _____

Current Medications: _____

Allergies _____

Surgeries: _____

Special Dietary Needs _____

Please circle if you have a history with any of these medical problems:

- | | | |
|------------------------------|-------------------------|-----------------|
| Hay Fever | Convulsions | Lung Problems |
| Bee stings | Blood Pressure Problems | Ulcers |
| Fainting | Cancer | Kidney Problems |
| Asthma | Heart Disease | Diabetes |
| Sulfa Drug Allergic Reaction | Poison Ivy or Oak | |
| Penicillin Allergic Reaction | | |

Other Illnesses or Conditions: _____

In case of emergency, please contact _____ who is _____ in relationship to me at phone number _____ Day _____ Night _____. Should I be in need of immediate medical care, I give permission for those in charge of the event to seek appropriate medical care for me, if I am unable to do so for myself.