

**California-Nevada Annual Conference  
The United Methodist Church  
YOUTH MEDICAL HISTORY AND AUTHORIZATION  
for VOLUNTEER CAMP STAFF**

The following information is required to ensure that your youth's individual needs are met while they are Volunteering as Camp Staff. The information is confidential and will be made available only to those adults who are directly responsible for your child's care.

Name \_\_\_\_\_ Male Female *(please circle)*

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Grade \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Father's Name \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

If divorced, who has physical custody? \_\_\_\_\_

*If parents cannot be reached in an emergency, please contact:*

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Insurance Carrier/Plan Name \_\_\_\_\_ Policy ID # \_\_\_\_\_

Carrier Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_

Date of Last Tetanus shot \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

Please list any allergies: \_\_\_\_\_ Vegetarian: Yes No

Taking any medications: Yes No Please list: \_\_\_\_\_

Is the participant under the direct care of a physician? Please explain: \_\_\_\_\_

\_\_\_\_\_

**RELEASE STATEMENT**

We, the undersigned(s) or legal guardian(s) of \_\_\_\_\_, a minor, do hereby authorize the adult leaders acting on behalf of the California-Nevada Annual Conference of The United Methodist Church, as agent, and working with other nonprofit agencies to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s), especially in case of emergency, to give specific consent to any such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his or her judgment may deem advisable. I agree to pay for any medical, dental, surgical, or hospital diagnosis, treatment, or care rendered to or for said minor.

\_\_\_\_\_ Parent/Guardian's Signature

\_\_\_\_\_ Date