EPWORTH CENTER HEALTH FORM

To be completed by each person in the Work Mission Program. Please print clearly.

Name of SOWER Group: ________________________________ Dates attending Work Mission: __________

Participant Information

Name: ________________________________ Date of Birth: ___/____/____ Phone: (____)_____________
Male / Female

Street Address: ___________________________________ City: ______________ State: ____ Zip: ________

Home Church Contact Person: _____________________________ Phone (_____)__________________

Parent/Guardian/Spouse Information

Spouse Name: ______________________ Home Phone: (_____)____________ Day Phone: (____)_________

Mother's Name: ____________________ Home Phone: (_____)____________ Day Phone: (____)_________

Father's Name: _____________________ Home Phone: (_____)____________ Day Phone: (____)_________

If Parent/Guardian/Spouse is not available in an emergency please notify:

1. Name: ___________________________ Relationship: ___________________ Phone: (____)_____________
2. Name: ___________________________ Relationship: ___________________ Phone: (____)_____________

Health Information

Dietary Needs: ____

Medication Allergies: ____
Reaction: ____

Other Allergies (food, hay fever, insect bites, asthma, etc): ____
Reaction: ____

Last Physical Exam Date: _____________ Doctor: ______________________

Past & Present Medical Conditions: ____

Last Tetanus/ Booster Date: ___________________ (if over 5 years, check with your physician)

Insurance Co.: ______________________________ Address: ______________________ Policy No.: _______

Preferred Family Doctor: _________________________________ Phone: (_____)____________________

Preferred Family Dentist: _________________________________ Phone: (_____)____________________

Preferred Eye Doctor: ___________________________________ Phone: (_____)____________________

Preferred Hospital: _____________________________________ Phone: (_____)____________________

Do you or this youth have any conditions that would prevent full participation in this program? [ ] YES [ ] NO

If yes, please explain: ____

PERMISSION AND EMERGENCY MEDICAL AUTHORIZATION

In the event the above person is unable to answer for themselves or is under 18 years of age and the parent or guardian cannot be reached, permission is herby granted for necessary emergency medical treatment by a certified first aid person and/or a licensed medical professional.

Signature: (circle one) Parent/Guardian/Adult Participant/Staff __________________________ Date: _________

Notarization of Health Form STATE OF ________ s.s. COUNTY OF _____________________

On this _______ day of __________, 20____, before me personally appeared __________________________________ to me known to be the same person described in and who executed the within instrument, and who acknowledged the same to be the free act and deed thereof. Signed _________________________________ Notary Public, ______________ County, State of _____. My Commission Expires __________________.

1 copy of this form is to be sent to the Epworth Center
The original, notarized form is to be kept with the participant in the vehicle en route to/from and during his/her stay.