



PERSONAL HEALTH

(To be filled out all participants)

To be filled out by parent, guardian, or adult participant. **Please print in ink.**

IDENTIFICATION

Name _____ Date of birth _____ Age _____ Sex _____
Name of parent or guardian _____ Telephone _____
Home address _____ City _____ State _____ Zip _____
Business address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT:

Name _____ Relationship _____ Telephone _____
Name _____ Relationship _____ Telephone _____
Name of personal physician _____ Telephone _____
Personal health/accident insurance carrier _____ Policy No. _____

ALLERGIES: Food, medicines, insects, plants Yes ___ No ___ Explain: _____

List any **medications to be taken at congress**, including drug, dosage, route (oral, injection, etc.), and frequency:

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: _____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: _____

I give permission for full participation in VEYS programs, subject to limitations noted herein.

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Participant's Signed Here

Date