ADULT Medical Form

Winter Connection

Dakotas Conference Council of Youth Ministry

DakYouth
Dakotas Conference
THE UNITED METHODIST CHURCH

This form is REQUIRED for all attendees AGE 18+. Please turn in at Event Check-in

Name: _____ **Date of Birth:** _____
Please print First Name Middle Initial Last Name

Home Address: _____ **Cell phone:** _____
Street Address

City: _____ **State:** _____ **Zip:** _____ **e-mail:** _____

1. Date of your most recent **tetanus immunization** (Month & Year): _____

2. **Nutrition** status/**dietary** needs:
   - ☐ I have no food allergies.
   - ☐ I am allergic to the foods listed here: _____
   - ☐ Describe symptoms and treatment if you are exposed to these foods:
     _____
     _____
   - ☐ I have the following **dietary restrictions/modifications**:
     _____

3. Please list **current medications** (prescribed and over-the-counter):
   _____
   _____

4. Do you have a **health condition** such as a chronic illness or a **special circumstance** that we should know about because it impacts your ability to participate in this program?
   - ☐ No, I am prepared to fully participate.
   - ☐ Yes, as explained:_____

5. **Emergency Contact Information**:

   Name of Individual: _____ Relationship to you: _____

   Preferred Phone: (____)_____ Alternate Phone: (____)_____

6. Things you should know about health services while you are at Winter Connection:
   a. In case of an emergency, we will contact local ambulance or emergency services. It may take a while for an ambulance or emergency services to reach each location. Please contact your event leader for specific information.
   b. Adult youth directors/chaperones/local church adult leaders are in charge of managing all medications for themselves and their participants. Please encourage participants to bring only what they anticipate needing during the event. Any/all personal medications must be stored securely while attending the event, either discreetly in a locked vehicle or in a designated space within lodging. In the event of emergency, we advise each participant to come with a full list of current medications.
   c. There may be clinics, hospitals, and pharmacies available to you within close proximity of the event location. Please contact the event leader for specific information.

Statement of Agreement

I understand my health information will be shared with event staff on a "need to know" basis and that, as an adult participant, I retain primary responsibility for managing my health while at this event. I agree to inform the event leaders of any changes that might impact my participation.

Signature: _____ Date: _____
Adult Participant