

**MEDICAL AUTHORIZATION FOR TREATMENT  
OF A PARTICIPANT: (ADULT)**



For the Illinois Conference Youth Initiative Spring Retreat  
Friday 12 March through Sunday 14 March 2010  
Pilgrim Park; 26449 1340 North Avenue; Princeton, IL 61356-8790  
815-447-2390 – www.il-odm.org

Please send all information to:

Rev. Paula R. Comper

P.O. Box 328

Beecher, Illinois 60401

**(I must have original copies before the due date. Please do not fax information or send information to the conference office. All information must be received by Monday 1 March 2010.)**

*(This medical release information is for the ICYI Spring Retreat only. Please note, there are 2 pages.)*

I request and authorize the area hospitals, medical staff personnel, agents and employees, to have access to information contained in this form and to provide all medical care, routine tests, treatment and necessary transportation advisable for my health. I acknowledge that no representations, warranties or guarantee as to result or cures will be made. I hereby give permission to medical staff to secure and administer treatment, including hospitalization for me (as named below). If I cannot make decision on my own behalf, I give permission of the medical guardian (as named below) to make those decisions for me and on my behalf. (Adults: If you do not have someone who is your medical guardian, who can make medical decisions on your behalf incase you cannot, you may want to name someone for this purpose.)

The name of the adult covered by this authorization is:

\_\_\_\_\_

*(last name)*

*(first name)*

*(middle name)*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(should not be of the same household)*

**Home Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State/Zip Code:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Medical Guardian:** \_\_\_\_\_

*(Someone who can make medical decisions on your behalf incase you are unable.)*

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## HEALTH CARE INFORMATION

Date of Last Tetanus Shot: \_\_\_\_\_

Name of Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you carry family medical/hospital insurance? (Yes – No)

If so, indicate Carrier: \_\_\_\_\_

Policy/Group Number: \_\_\_\_\_

Are you currently under the care of a physician? (Yes – No)

If yes, who is your physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have allergies to medication, food, plants, insects, etc.? If so, please list.

Please list prescribed medications you will have in your possessions?  
(This information will be helpful to emergency room/ambulance personnel.)

Please list additional health information (surgery or serious injuries, chronic or recurring illness/medical condition such as epilepsy, diabetes, heart disease, etc.) that would be helpful for an attending physician to know in case of an emergency:

### RESTRICTON

### WHILE AT THE ILLINOIS CONFERENCE YOUTH INITIATIVE SPRING

### RETREAT

Pilgrim Park, Princeton, IL; Friday 12 March through Sunday 14 March 2010

**Please Note:** If you think your child will need such over-the-counter medications as Advil, Tylenol, aspirin, cold medication, etc., please make sure she/he packs it along for this event. The Illinois Conference or your child's chaperone/pastor cannot administer such medications so as to remove all liability in case such medication interacts with other things your child may have taken.

I understand this notation:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

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