REGRESO A CASA
A New Age of Faith
#EYE23

Episcopal Youth Event 2023
Personal Health & Medical Information / Authorization

This Agreement and Release is between _____ ("PARTICIPANT") and The Domestic and Foreign Missionary Society ("DFMS") regarding the participation of Participant in the 2023 Episcopal Youth Event.

In the event of an accident or serious illness, I hereby authorize the Staff Officer or an event staff member to obtain medical treatment for Participant. I hereby hold harmless and agree to indemnify DFMS from any claims, causes of action, damages and/or liabilities, arising out of or resulting from said medical treatment. I further agree to accept full responsibility for any and all expenses including medical expenses that may derive from any injuries to Participant that may occur during his/her participation in the Event.

If I cannot be reached by phone, the Staff Officer or one of the conference staff members has my permission to authorize medical treatment for Participant. This authorization includes the securing of medical, dental, emergency or hospital treatment, including surgery, x-rays, drugs and anesthesia. I hereby certify that I have read and fully understand the above authorization for medical treatment. I accept all financial responsibility for the same. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

☐ By checking this box, I agree that my typed name shall be considered my signature and acceptance of these terms.

Parent/Guardian 1 Signature	*Date*	*Parent/Guardian 2 Signature*	*Date*
Cell/Home phone number		*Cell/Home phone number*	

Does Participant have health/accident insurance? ◉ **YES** ○ **NO**
If yes, please send your registrar a copy of the front and back of Participant's insurance card. *If participant does not have health/medical insurance, they will be covered by DFMS for this event.*

Insurance carrier:	Group Number:
Policy holder Name:	Policy holder Date of Birth:
Member Identification Number:	

☐ **I certify that Participant is up-to-date on childhood vaccines and their Covid vaccination (Initial round + booster, as eligible).** ***Please send a copy of Participant's Covid vaccine card to your delegation registrar.***

Date of last tetanus shot:	

Signature:	*Relationship to Participant*

The Staff Officer or event staff have minor first aid supplies. If Participant becomes ill or suffers a minor injury, we must have parental authorization to dispense medications. Below is a list of common over-the-counter medication. By checking, I authorize that the following medications may be given to Participant if the need arises. I shall indemnify and hold harmless the staff and all officers, directors, employees, and agents against any claims that may arise relating to the administration of these over-the-counter medications.

The following over-the-counter medications may be administered (check all that apply):

- ☑ Sunscreen
- ☑ Bug repellent
- ☑ Ointments for minor wound care or first aid as directed, including antiseptic, anti-itch, anti-sting, antibiotic, sunburn.
- ☑ Tylenol/Acetaminophen as directed.
- ☑ Ibuprofen as directed.
- ☐ Throat lozenges and/or spray as directed for sore throat.
- ☐ Hydrocortisone ointment as directed for mild skin irritations, rashes, insect bites.
- ☐ Medicated powder for skin irritation as directed.
- ☑ Medicated lip ointment for dry, chapped lips, lip blisters or canker sores as directed.
- ☐ Kaopectate or Imodium for diarrhea as directed.
- ☐ Milk of Magnesia, Pepto-Bismol, or Mylanta for upset stomach or nausea as directed.
- ☐ Rolaids or Tums for acid reflux, heartburn, or indigestion as directed.
- ☐ Benadryl for swelling, hives, allergic reaction as directed.
- ☑ Actifed or Sudafed as directed for nasal congestion or allergy relief as directed.
- ☑ Visine or other eye drops for minor eye irritation.
- ☑ Robitussin or other cough syrup as directed.

Does Participant have medical conditions that staff should be aware of? ◉ YES ○ NO

Please provide all relevant details.

_____

Does Participant have a history of allergies or reactions to food, medications, insect stings, or plants? ◯ YES ◯ NO

Please provide all relevant details.

_____

☐ Check here to indicate that participant will carry an inhaler

☐ Check here to indicate that participant will carry an Epi-pen

Does Participant have insulin-dependent diabetes? ◯ YES ◯ NO ***Please provide all relevant details.***

_____

Does Participant manage carb counting and insulin dosage on their own? ◯ YES ◯ NO

How long has Participant had diabetes? _____

Does Participant take any prescription medications?

Please complete this section accurately and completely. List all medications and treatments prescribed to Participant, including: lotions, creams, inhalers, liquids, allergy medications, cold medications, injections, and temporarily prescribed medication, including all over the counter medications, vitamin/mineral supplements, herbs, homeopathic remedies, and other treatments. ***Prescription medications must be in original and current container.***

If changes to medical condition and/or medication occur and are different from what is listed on this form, please notify us upon arrival at EYE23.

Name of Medication	***Dosage***	***Time(s)***	***Comments/Instructions*** *(Take with water, dissolve tablet, etc.)*

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