

ADVISOR MEDICAL HISTORY FORM

Name (last, first): _____

Date of Birth: _____ Age: _____

Address _____

City: _____ State: _____ Zip: _____

Physician's Name _____ Phone: _____

Physician's address: _____

Hospital of Choice: _____ Tel#: _____

Dentist's Name _____ Tel#: _____

Address: _____

Any medical problems ? _____

Are you taking either prescription or over-the counter medication on a regular basis? Yes/ No

Name of drug/ dose/ time of day it is taken _____

Physician prescribing drug: _____

Do you have any drug allergies? Yes / No

If yes, Name of Drug(s): _____

Other Allergies: _____

Type of Reaction (be specific): _____

Comments: _____

List names and telephone numbers of three persons to contact if you are ill or injured. These persons may have to make a medical decision in case of an emergency.

1. Name _____ Relationship _____ phone _____

2. Name _____ Relationship _____ phone _____

3. Name _____ Relationship _____ phone _____

EMERGENCY MEDICAL TREATMENT

To the Advisors, Coaches and Clergy:

In the event that I am unable to be reached and I need EMERGENCY MEDICAL TREATMENT during the time I am participating in the GOYA retreat, you have my permission, and I hereby designate you my agent, to act in my best interest in obtaining necessary transportation and medical care until someone can be contacted. I hereby release you from any claim arising out of your and the doctor's actions relating to my illness/injury, and I assume and agree to pay for any professional medical services and other fees/costs incurred.

Signature: _____ Date _____

Permission for emergency medical treatment will be effective throughout your Goyan's enrollment. If there is any change of information, please contact either the Clergy or Advisors.

Name of Insured: _____

Insurance Company _____

Group Identification # : _____ Member # _____

Telephone # _____

_____ Attached is a copy(front and back) of the Insurance Card of the Insured-stapled to this form.