

Freedoms Foundation at Valley Forge

Adult Information Form

(Must be printed or typed)

Full Name: _____

M

F

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone : _____ Cell Phone: _____

E-Mail: _____

Organization: National Sojourners Chapter: _____

Conference Date: July 14 – 17, 2011 _____

PLEASE RETURN COMPLETED FORM TO FREEDOMS FOUNDATION

Revised May 2011

ADULT MEDICAL INFORMATION FORM

This form consists of TWO sections. In order to be admitted to the Conference, each section needs to be completed with the required signature and be received by the Freedoms Foundation Programs Office prior to the program or be submitted by the participants upon arrival on the Freedoms Foundation campus. We are required to have this information on file in case of an emergency.

NAME _____

I. INSURANCE

Freedoms Foundation does not carry medical insurance to cover participants. All participating students should be covered by personal or family insurance.

I hereby certify, under penalty of perjury, that the above named individual is covered by the insurance company listed below.

Signature _____ Date _____

Insurance Company _____

Policy/Group number _____

Expiration Date of insurance _____

I do not have medical insurance and shall be held responsible for any costs incurred _____
Initials

I hereby release and discharge Freedoms Foundation at Valley Forge, its officers, agents, instructors, and employees, from any and all claims, demands, suits, actions or causes of action which I may or shall have by reason of any illness, injury or accident incurred or suffered by the above named participant at this conference and in the course of travel by any means and while on the premises of Freedoms Foundation at Valley Forge, no matter how caused or occasioned.

Signature _____ Date _____

Please list emergency number(s) at which the closest relative may be reached during the conference.

Name _____ Telephone _____

Name _____ Telephone _____

(OVER)

III. ADULT MEDICAL HISTORY

Name of Participant _____

Name of Physician _____

Physician's Address _____

City _____ State _____ Zip Code _____

Physician's Telephone _____

Date of most recent exam _____

Date of most recent tetanus toxoid immunization _____

HISTORY

CONDITIONS

- Frequent ear infections
- Heart defect/disease
- Convulsions
- Diabetes
- Bleeding/Clotting disorders
- Hypertension
- Mononucleosis
- Hepatitis

ALLERGIES

- Hay Fever
- Ivy poisoning, etc.
- Insect Stings
- Asthma
- Penicillin
- Other Drugs

IMMUNIZATIONS

- Chicken Pox
- Measles
- Mumps
- Rubella
- DTaP

Food Allergies _____

Current Medication taking _____

Medication allergies _____

List any condition or illness that Freedoms Foundation should be aware of that is not mentioned _____

