Just5Days
Adult Health Form

(Your signature at the end indicates your consent and acceptance of the provisions included in this document.)

Just5Days *P*rogram Site ____

Program Starting Date (month/day/year) ______________________________________

Participant Name ______________________________ Date of Birth _________________

Parish/School _____________________________ City & State ____________________

Mailing Address ____

City/State/ZIP ____

Name and number to call in an emergency_____________________________________

LIABILITY WAIVER: I will not hold the Center for Ministry Development, the program facility, or the service agency responsible in the event of any injury or accident to my person while participating in the ***Just5Days*** program and/or traveling to and from program activities.

USE OF PHOTOS: I give the Center for Ministry Development permission to use photos or videos of me taken during program activities for future program promotion purposes.

STATEMENT OF HEALTH: I hereby warrant that, to the best of my knowledge, I am in good health and able to participate in all program activities. (Please submit a statement indicating limitations and/or conditions of which we should be aware.)

<u>INSURANCE INFORMATION</u>

Family Health Insurance Co.: _____________________ Policy No. __________________

Date of Last Examination: ____

Physician or Clinic: _______________________________ Phone ___________________

Physician/Clinic Address ____

IMMUNIZATIONS: (Please provide date of latest tetanus immunization) _________________

MEDICATIONS: Any medications brought to the program should be clearly labeled and in their original container. Please list any prescription or non-prescription drugs you are presently taking.

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ALLERGIES: Please list all known allergies, including how you are treated and with what medication. need.)

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OPERATIONS OR SERIOUS INJURIES (Within the past 18 months)

Operation/Injury ______________________________ Date ________________

COMMUNICABLE DISEASES: Please notify CMD if you have been exposed to any communicable disease (mumps, measles, chicken pox, etc.) within three weeks prior to attending the ***Just5Days*** program.

MEDICAL EMERGENCY: In case of medical emergency, I understand that every effort will be made to contact the person I have listed as my emergency contact. In the event that he/she cannot be reached, I hereby give permission to the physician selected by the ***Just5Days*** program director or parish adult leader to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for me.

Signature _________________________________ Date ___________________

RETURN TO: The leader of your parish or school ***Just5Days*** Team.

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