

Permission and Medical Release Form

Complete this form separately for each event or activity involving special considerations (see *Handbook 2: Administering the Church*, 13.6.20, ChurchofJesusChrist.org), an overnight stay, travel outside the local area, or an activity with higher than ordinary risks.

Event Details (to be filled out by event planner)			
Event		Date(s) of event	
Describe event and activities (please be specific)			
Ward		Stake	
Event or activity leader	Event or activity leader's phone number	Event or activity leader's email	
Participant Information			
Participant		Date of birth	Age
Primary telephone number <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Secondary telephone number <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Address		City	State or province
Emergency contact (parent or guardian)	Primary telephone number <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Secondary telephone number <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Medical Information			
Does the participant require a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain the dietary restrictions		
Does the participant have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list the allergies		
Is the participant taking any medication or over-the-counter (OTC) drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, can the participant self-administer his or her medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please contact the event or activity leader directly.		
List all prescription or over-the-counter (OTC) medications the participant is taking			
Physical Conditions That Limit Activity			
Does the participant have a chronic or recurring illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain		
Has the participant had surgery or a serious illness in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain		
Identify any other limits, restrictions, or disabilities that could prevent the participant from fully participating in the event or activity (attach additional pages if needed)			
Other Accommodations or Special Needs			
Identify any other needs or considerations the participant has that the event or activity planner should be aware of (attach additional pages if needed)			
Permission			
I give permission for my child or youth to participate in the event and activities listed above (unless noted) and authorize the adult leaders supervising this event to administer emergency treatment to the abovenamed participant for any accident or illness and to act in my stead in approving necessary medical care. This authorization shall cover this event and travel to and from this event.		The participant is responsible for his or her own conduct and is aware of and agrees to abide by Church standards, camp or event safety rules, and other pertinent instructions. Participants' conduct and interactions should abide by Church standards and exemplify Christlike behavior. Parents and participants should understand that participation in an activity is not a right but a privilege that can be revoked if they behave inappropriately or if they pose a risk to themselves or others.	
Participant's signature		Date	
Parent or guardian's signature (if necessary)		Date	

Goodyear Stake 2024 Moroni's Promise

Extended Health and Medical Form

Please Accurately complete this form. All medical information will be kept confidential by those with Moroni's Promise responsibilities.

Camper Name:		Ward:
Birthdate:	Weight:	Height:

MEDICAL CONDITIONS – Please check all that apply or check

☐ **NONE**

- | | |
|--|---|
| <input type="checkbox"/> Heart / Circulatory | <input type="checkbox"/> Muscular/Skeletal conditions |
| <input type="checkbox"/> Lung / Respiratory asthma | <input type="checkbox"/> Fatigue/Difficulty breathing w/exercise |
| <input type="checkbox"/> Kidney / Urinary | <input type="checkbox"/> Recent surgeries/injuries <i>please explain</i> |
| <input type="checkbox"/> Diabetes / blood sugar concerns | <input type="checkbox"/> Sleep disorders i.e., <i>sleep walking, night terrors</i> |
| <input type="checkbox"/> Seizures/Neurological/Fainting | <input type="checkbox"/> Vision/Hearing/Oral (<i>requiring our attention</i>) |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Physical equip i.e., <i>knee or ankle braces; crutches</i> |
| <input type="checkbox"/> Abdominal/Digestive i.e., <i>celiac/Crohn's</i> | <input type="checkbox"/> Other <i>any medical concern not listed</i> |

Explain conditions:

BEHAVIORAL/EMOTIONAL/MENTAL HEALTH CONDITIONS – Please check all that apply or check None

☐ **NONE**

- | | |
|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> PTSD, Recent Trauma, etc. |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Autism Spectrum | <input type="checkbox"/> Psychiatric conditions i.e., phobias, eating disorders, |
| <input type="checkbox"/> Behavioral concerns | <input type="checkbox"/> Other |

Explain condition's severity & how it is managed at home:

ALLERGIES – Please check all that apply or check

☐ **NONE**

☐ Epipen or Inhaler will be sent to camp

- | | |
|--|--|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Gluten intolerance |
| <input type="checkbox"/> Hay Fever/Plants | <input type="checkbox"/> Celiac |
| <input type="checkbox"/> Latex/Tape/Adhesive | <input type="checkbox"/> Dairy allergy/intolerance |
| <input type="checkbox"/> Insects | <input type="checkbox"/> Nut Allergies |
| <input type="checkbox"/> Environmental <i>i.e., metals, aerosols</i> | <input type="checkbox"/> Other dietary concerns |
| <input type="checkbox"/> Other | |

Explain allergy severity & how it is managed at home: (examples: Ibuprofen = hives)

REQUIRED DAILY MEDICATIONS - Please list both prescription and over-the-counter medications, or check ☐ **NONE**

<u>Medication</u>	<u>Dose - Strength</u>	<u>Frequency</u>

Is Camper currently covered by Medical Insurance policy?		YES	NO
Insurance Company		Policy Holder Name	
Policy #		Policy Holder DOB:	
Group ID #		Relationship to Camper	
I have completed this form to the best of my knowledge.		Initial	
I hereby certify that my child is in good health and is able to participate in all camp activities.		Initial	
The assigned health care professional may seek emergency medical attention for my child, should she/he deem it necessary.		Parent/Guardian Signature	
Parent/Guardian Signature:		Date	
Parent/Guardian Printed Name:		Cell #	
Email Address:			

EMERGENCY CONTACTS

NAME	PHONE #	RELATIONSHIP

Goodyear Stake Moroni's Promise
June 5-8, 2024

Camper's Name:	Ward:
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The following over-the-counter medications will be available at camp from the Health Care Registered Nurse.
Please circle Yes or No for each medication your child is permitted to receive:

Ibuprofen / Motrin / Advil / Aleve	Yes	No
Tylenol / Acetaminophen	Yes	No
Benadryl / Diphenhydramine	Yes	No
Tums / Antacid	Yes	No
Anti-diarrheal (Pepto Bismol)	Yes	No
Midol	Yes	No
Cough drops	Yes	No
Decongestant (Sudafed)	Yes	No
Antihistamine (Claritin / Zyrtec)	Yes	No
Dramamine (anti-emetic)	Yes	No
Silvadene (ointment for burns)	Yes	No
Hydrocortisone cream (anti-itch)	Yes	No

Are there any OTC medications you **do NOT** want your child to receive?

**ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINERS
& CHECKED IN WITH THE CAMP NURSE UPON ARRIVAL AT CAMP!**

Participant's Tunic Size (similar to adult unisex t-shirt sizing)

XS S M L XL XXL 3XL

Parent/Guardian Signature:	Date
Parent/Guardian Printed Name:	Cell #