CALVIN COLLEGE
Fridays At Calvin Group Travel and Participation
Medical Form

Medical information will remain confidential and will not be released except as allowed by law.

Participant's Name: _____ Age:_____ Gender: M/F

Address: _____ Birth Date: _____

City: _____ State: _____Zip: _____ Home Phone: _____

Participant's Cell phone:_____

Parent's Name (1): _____ Daytime Phone: _____

Parent's Name (2): _____ Daytime Phone: _____

Family physician: _____ Phone: _____

Insurance Company: _____ Policy#: _____

Policy Holder: _____

Designated alternate if parent is unavailable:

Name: _____ Phone: _____

Please identify any significant medical conditions (i.e. asthma, diabetes, allergies/reactions to medications, foods, bee stings etc.), major illnesses, or injuries that may affect your child's participation in Calvin College activities.

_____

_____

Does your child take any medications at home? If so, please list them below. *(Be sure to send medication with your child on this trip. Prescription containers should be used and packed where they can be easily located.*

I understand that Calvin College does not provide medical insurance for program participants. I hereby confirm that my child is covered by the health insurance policy listed above. I authorize Calvin College or its designated person to secure medical attention for my child if any such person deems necessary if I am not available to make a decision regarding such medical attention. This consent shall not impose any obligation to provide such medical attention and it is understood that such persons might not be trained medical personnel. I hereby authorize the Grand Rapids emergency health care system or any other system where my child is presented in need of care to provide any necessary care.

Signature of Parent or Legal Guardian: _____ Date: _____

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