Young Adult Westminster Woods Camp Health Information Form

Please return this form immediately.

Do NOT wait for arrival.

Please turn this form in with your registration

Valid January 1, 2024 – December 31, 2024

INFORMATION (please print):

Your Full Name ____

Address: ____City: ______________ State: _____ Zip________

Gender: _______ Date of Birth: _____/ _____/ _____

HEALTH INSURANCE INFORMATION:

Health Insurance Company: ________________________________ Phone Number: ______________________

Policy Number: __________________________________ Group Number: _______________________________

MEDICAL HISTORY and EMERGENCY CONTACT INFORMATION:

Do you have a communicable disease or medical condition that may be a risk to others? Yes or No
If yes, please describe: ____
Do you have any drug allergies? Yes or No
If yes, please describe: ____

Please describe any special considerations regarding Minor(s) (medical conditions, food allergies, dietary restrictions, activity limitations, asthma, ADHD, behavioral issues/concerns, etc.):

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I hereby authorize medical treatment by any licensed hospital at the discretion of Brian or Diane Wheeler for the above-named person at this retreat/camp sponsored by Westminster Woods Camp & Retreat Center, Inc. I also herby authorize the making of photographs, motion pictures, videotapes, recording, or other memorializing of said event and for my (or my child's) participation therein, and the publication or other use thereof, I waive any right to compensation therefore or any right that I otherwise might have to limit or control such making or use. I agree to cooperate and conform to directions and instructions of personnel responsible for activities. I will indemnify and hold harmless Westminster Woods Camp & Retreat Center, Inc. and its officers, agents, servants, or employees from any and all claims or causes of action by myself or by any other person or entity, and under no circumstances will present any claims against said organization and said persons for personal injury, property damage, wrongful death caused by any act of negligence by the camp. Recourse for the payment of any hospital, medical, dental, or related cost and expenses will be paid either by me or my accident, hospital or medical insurance, or any available benefit plan of mine.

Legal Signature

Print Name: _______________________________

Signature: ______________________________________ Date: _________________