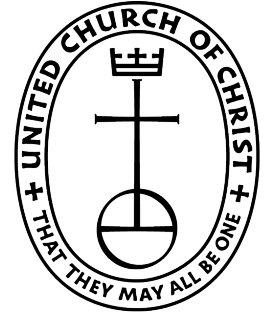


NEW YORK STATE YOUTH EVENT  
NY CONFERENCE UNITED CHURCH OF CHRIST



Theme: G(o)od Vibes

Watson Homestead, Painted Post, NY

March 6-8, 2020

HEALTH FORM

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Complete Address

\_\_\_\_\_  
(Number and Street) (City) (State) (Zip)

Emergency Contact: Name: \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_  
(Number and Street) (City) (State) (Zip)

Phone (Daytime): (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (Evening): (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Is Applicant  
Subject to: Asthma Bronchitis Cardiac Condition Diabetic Epilepsy Headaches Sinus  
Problem Other: \_\_\_\_\_

Medications (All medications must be in the original container):

Recommendations as to Physical Exertion: Heavy Moderate Limited

Insurance Information:

Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Complete Address: \_\_\_\_\_

Parental Permission for Treatment:

I hereby authorize my daughter/son \_\_\_\_\_ to receive medical attention if necessary while a participant at the UCCNY State Youth Event. I authorize my child's youth advisor or any advisor over 21 years of age to act on my behalf in these matters.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_