MEDICAL INFORMATION- Cody Cowboy Church Bunkhouse

Name:_____

Address:_____

City/State/Zip Code_____

Date Of Birth:_____ Age:_____Phone #_____

If under 18, please fill out this section also:

Parent/Guardian Name:_____

Parent Phone # Cell_____Work_____

Address if different from above:_____

In case of an emergency, please contact: Name_____

Contact phone #_____

Other phone #_____

Family Physician:_____Phone #_____

Insurance Company:_____Phone #_____

Policy Number:_____

Policy holder name:_____ID#_____

Policy Holder's Place of Employment:_____

Permission for Medical Treatment, Photograph and Video Notice, and Release of Liability

My permission is granted for Cody Cowboy Church, Bunkhouse Ministry, Corporate Leadership, and Summer Bunkhouse Supervisor to obtain medical attention in case of sickness or injury to me or my child. I do hereby consent to allow transportation to a proper medical facility if required by medical emergency. I do hereby consent for all medical care prescribed by a duly licensed doctor of medicine for me or my child.

I do also understand that while staying at the bunkhouse, me or my child may be photographed and/or videotaped during normal cowboy church/bunkhouse activities and events and that these photos and/or videos may be used in promotional materials.

Finally, I, the undersigned do hereby verify that the above information is correct and I do hereby release the Cody Cowboy Church, Bunkhouse Ministry, corporate Leadership, Supervisors, Sponsoring churches, State/National Conventions and their employees from any and all claims, demands, actions, or causes of action, suit, and liabilities arising out of attending the Bunkhouse Ministry of Cody Cowboy Church in Cody, WY while me or my child is on church designated property.

Complete and Sign Below (**if under 18 years of age and parent will not be here to sign**, we require Parent/Legal Guardian **notarized** signature)

Cowboy Signature_____ Date_____

Parent/Legal Guardian Signature_____ Date_____

On the_____ day of _____, _____, before me, _____, the undersigned Notary Public,

Day Month Year Printed Name of Notary

appeared _____.

Name of Signer

☐ Personally known to me –OR-

☐ Proved to me on the basis of satisfactory evidence

To be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same for the purposes therein stated.

WITNESS my hand and official seal

_____

Signature of Notary Public

Notary Seal

MEDICAL PROFILE

HAVE YOU EVER HAD COVID-19 VIRUS? Yes_____ No_____

IN THE PAST MONTH, HAVE YOU BEEN IN CONTACT WITH ANYONE HAVING THE COVID-19 VIRUS? Yes_____ No_____

Generally your health is (check one) _____Excellent _____Good _____Fair _____Poor

Current Medications (prescribed or otherwise)

Medication name Dosage

_____

_____

_____

Conditions for which you are currently being treated

_____

_____

Health issues we need to be aware of_____

(Asthma, Bronchitis, Diabetes, Stomach ulcer, Kidney trouble, heart issues, etc.)

Allergies (food, medicine, or any other substance)_____

_____

Previous operations or illnesses_____

Special dietary needs or concerns_____

Date of last tetanus immunization____/___/_____/_____

IF I AM FEELING SICK, I WILL ALERT THE BUNKHOUSE FOREMAN OR PASTOR PAT ASAP! _____

_____ _____

Signature Date

_____ _____

Parent/Guardian Signature (if under 18) Date