

**HEALTH FORM
2010 NY CONFERENCE UCC
YOUTH EVENT
www.uccny.org**

"Connect the Dots"

**Watson Homestead, Painted Post, NY
March 5-7, 2010**

Name: _____ Birth Date: _____ Phone: (____) ____ - _____

Complete Address _____
(Number and Street) (City) (State) (Zip)

Emergency Contact:

Name: _____ Relationship _____

Complete Address _____
(Number and Street) (City) (State) (Zip)

Phone (Daytime): (____) ____ - _____ (Evening): (____) ____ - _____

Is Applicant Subject to:

Asthma Bronchitis Cardiac Condition Diabetic Other: _____
Epilepsy Headaches Sinus Problem _____

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

Name of Medication	Dosage	Reason Taken

Recommendations as to Physical Exertion: Heavy Moderate Limited

Restrictions: Swimming Diving

Insurance Information:

Insurance Carrier: _____ Policy Number: _____

Policy Holder's Name: _____ Relationship: _____

Doctor's Name: _____ Phone: (____) ____ - _____

Complete Address _____
(Number and Street) (City) (State) (Zip)

Parental Permission for Treatment:

I hear by authorize my daughter/son _____ to receive medical attention if necessary while a participant at the 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: _____