

Messiah University Young Writers Workshop  
Medical Form

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_

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

Place of Employment: \_\_\_\_\_

Home Phone:(\_\_\_\_)\_\_\_\_\_ Work Phone:(\_\_\_\_)\_\_\_\_\_

Another Person who will likely know where you can be reached:

Name: \_\_\_\_\_ Phone:(\_\_\_\_)\_\_\_\_\_

If you plan on being away from home during camp, please indicate how we can contact you in case of emergency: \_\_\_\_\_

Name of Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

In whose name is the insurance listed?: \_\_\_\_\_

Does the participant have any special dietary needs? Yes No If so, please describe:

\_\_\_\_\_

Does the participant have a disability that requires special accommodations? If so, please describe:

\_\_\_\_\_

\_\_\_\_\_

Please read, date and sign:

If my child needs medical treatment while participating in the workshop, it is my wish that treatment be started immediately if it is deemed necessary by a physician, with the understanding that every effort will be made to notify me in case of any major injury or illness. I will accept responsibility for all costs related to such treatment.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Medications

Please list any medications your child is currently taking:

Prescription: \_\_\_\_\_

Over the Counter: \_\_\_\_\_

Drug Sensitivities: \_\_\_\_\_

Allergies: \_\_\_\_\_

Please circle any of the following that you approve workshop staff, including the designated resident assistant administer to your child? (circle)

Tylenol

Benadryl

Tums

Students, please read, date and sign the following I, \_\_\_\_\_, am aware that I may NOT share any medications with other participants.

Signature of Participant: \_\_\_\_\_ Date \_\_\_\_\_

Parents, please read, date and sign the following:

\_\_\_\_\_ will bring the following medications with him/her to the workshop. He/she  
(name of participant)

has my permission to take them, only as dispensed by his/her designated resident assistant, and only according to the prescribed directions on the container. He/she may not share them with any other participant.

Medications: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date \_\_\_\_\_

Mail or email to:

**Messiah University**  
Young Writers Workshop  
One University Avenue, Suite 3009  
Mechanicsburg, PA 17055  
youngwritersworkshop@messiah.edu