St. John's United Church of Christ

Health & Medical Information - Child/Youth

Participants Personal Information

Name ______________________ Birth Date ______________________

Address ______________________

City ______________________ State ______________________ Zip Code ______________________

Parent/Guardian ______________________

_(_____)______________ Cell Phone Number

_(_____)______________ Home Phone Number

_(_____)______________ Work Phone Number

Emergency Contact Information

Name ______________________

Relatonship to Participant: ______________________

_(_____)______________ Cell Phone Number

_(_____)______________ Home Phone Number

_(_____)______________ Work Phone Number

Name ______________________

_(_____)______________ Cell Phone Number

_(_____)______________ Home Phone Number

_(_____)______________ Work Phone Number

Physician Information

Name ______________________ Phone Number ______________________

Are activities restricted: ☐ Yes ☐ No If yes, please explain: ______________________

Health History

I. Allergies:

Does your child/youth have any allergies or medical condition that we should know about:

____

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II. Check if your child/youth wears or uses any of the following:

☐ Epipen ☐ Gluopen ☐ Inhaler

☐ Contact Lenses ☐ Glasses ☐ Dental Appliance ☐ Other ______________________

Please List All Current Medications

Are any needed during activities? ☐ Yes ☐ No - If yes please let which ones below.

The Following Over the Counter Medicines May Be Given to My Child

Tylenol	☐ Yes	☐ No	Calamine Lotion	☐ Yes	☐ No
Antiseptic Ointment	☐ Yes	☐ No	Benadryl	☐ Yes	☐ No
Ibuprofen	☐ Yes	☐ No	Insect Repellent	☐ Yes	☐ No

TREATMENT AUTHORIZATION

Parent/Guardian Statement: This health history is complete and accurate. I know of no reason (s), other than indicated on this form, why my child should not participate in activities except as noted. I authorize the adult leader in charge to consent to medical treatment when either I or my assignee cannot be . contacted. I understand every effort will be made to contact me before such action.

I further authorize the adult leader(s) to administer prescription medications in case of emergency.

Parent/Guardian Signature

Date