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:

_____

_____

_____

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 _____