Health Form

Holston Conference UMC Youth Ministry

A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD MUST BE STAPLED TO THIS FORM

Participant Name _____ SS#_____
Birth Date: _____ Gender: ____ Age: ____ Grade (if summer event, grade in fall):_____

Insurance Company:_____ Policy #_____
Insurance Subscriber's Name:_____ ID#_____
Subscriber's Date of Birth:_____ SS#:_____
Insurance Claims Address:_____
Pre-Authorization Phone # if required (___) _____

Parent/Guardian/Spouse:_____ Home Phone:(___) _____
Address:_____ Work Phone: (___) _____
City:_____ State:_____ Zip:_____ Cellular Phone:(___) _____

In an emergency situation, use these contacts as necessary:
Second Parent/Guardian:_____ Home Phone:(___) _____
Work Phone:(___) _____ Cellular Phone:(___) _____

Emergency Contact:_____
Home Phone:(___) _____ Work Phone:(___) _____
Participant's Physician:_____ Phone:(___) _____

Has participant ever had the following? Answer Yes or No. If yes, include the date.
Ear Infections:_____ Chicken Pox:_____ Measles:_____ Mumps: _____
Frequent Headaches:_____ Mumps:_____ Convulsions:_____ Bleeding Disorders:_____
ADD/ADHD:_____ Fainting:_____ Diabetes:_____ Other: _____
Operations:_____
Serious Injuries: _____
Mouth Braces:_____ Is participant a sleepwalker?:_____

Has participant ever had an allergic reaction to: (describe)
Hay fever:_____ Ivy Poisoning:_____ Insect Stings:_____
Penicillin:_____ Other Drugs:_____
Asthma:_____ Foods:_____

Does participant have other special considerations?
Chronic problems: _____
Emotional or behavioral problems:_____

This health history is correct so far as I know.

In signing this authorization, I acknowledge that I have read the event description and am aware that the activities associated with this event entail certain inherent risks including damage to property, personal injury, and even death. In consideration for being permitted to participate in this event, I agree to assume all such risks and hereby release and discharge the Holston Conference of The United Methodist Church, its affiliated agencies, officers, sponsors, trustees, employees, agents and other aids and/or volunteers from any and all liability for any and all damage, loss, injury, or death of every kind and nature whatsoever which in any way arises out of the participant's participation in this event.

The participant has permission to engage in all prescribed event activities except as noted:_____.

I hereby give permission to the event staff to provide routine health care, administer prescription drugs, and seek emergency medical treatment including ordering X-rays and/or routine tests. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by an event adult leader to hospitalize, secure proper treatment, and to order injection and/or anesthesia and/or surgery for me/or my child as named above.

I give permission for me/my child to be transported in a private vehicle if necessary.

I give permission for photographs taken of me/or my child to be used for Holston Conference UMC publicity, printed or electronic.

Signature of parent/guardian or adult participant:_____

This form may be photocopied for use off of event site. **Date**_____

- - - - - - - - - - - - TO BE COMPLETED BY NOTARY - - - - - - - - - - - -

STATE OF _____ **COUNTY OF** _____

I, _____, notary public in and for said county in said state, hereby certify that

_____, whose name is signed to the foregoing conveyance, he executed the same voluntarily on the day the same bears date.

Given under my hand and seal of office this _____ day of _____, 20____.

Notary Public in and for the State of _____

Printed Name: _____

Commission Expires: _____ SEAL:

Activities limited:_____
Special Diet:_____
(For Female)
Has participant menstruated?_____ If not, has she been told about it?_____
Is menstrual history normal?_____ Special considerations:_____

Immunization History - Give date of most recent immunization or booster:

Tetanus:_____ Tetanus Booster:_____ Polio:_____
Mumps:_____ Measles:_____ Rubella:_____
DPT:_____ Hepatitis B_____ Hepatitis A:_____
Tuberculin Test:_____ Other:_____

Over-The-Counter Medications - By checking the appropriate line, I DO NOT give permission for the participant to receive the following over-the-counter medications.

Symptom	Medication
Headache, Fever	Acetaminophen (Tylenol)____
Cramps, Muscle Pain, Inflamation,	Ibuprofen_____
Upset stomach	Maalox _____Mylanta_____
Diarrhea	Donagel_____Kaopectate_____Imodium Liquid____
Localized Allergic Reactions	Benadryl____
Sore Throat	Sore Throat Lozenge_____
Congestion	Decongestant Medication (Oral) _____
Sneezing, Itching	Antihistamines (Oral) _____
Itching (Rash)	Hydrocortisone Cream _____Calamine Lotion_____
Insect Sting	Insect Bite Relief (Sting Kill) ointment_____
Mosquito Protection	Lotion containing DEET_____
Sun Burn Protection	Sunscreen Lotion _____

Without specific parental authorization, no oral medications will be given that are not listed here.
List any other over-the-counter oral or topical medications which your child should not receive:
_____

All medications brought to event, both prescription and non-prescription, must be in the original containers and clearly labeled with Participant's name. All prescription medications will be dispensed according to physician's instructions. My child has my permission to take the medication that he/she brought to the event. Signed: _____ Date:_____

Prescription and Routine Medications – Please list all medications brought by participant to be taken regularly throughout the event, listing exact dosage and dispensing orders prescribed by your doctor. Medications must be in original containers.

Medication	Dosage	Times Taken (Breakfast, Lunch, Supper, Bed, Other)

Parent/Guardian Signature verifying instructions:_____ Date _____

Physician's signature required if dispensing
orders differ from original container's label: _____ Date _____

Departure of participant from event:

Please send a note if your child will be leaving the event early, when they will be leaving, and who will be picking the child up.

FOR EVENT STAFF USE ONLY

To be completed when participant is checked out.
Participant checked out by (signature) _____ Date_____
Did parent receive remainder of personal medications? Yes No N/A