HEALTH FORM – YOUTH PROGRAMS

First Congregational Church UNITED CHURCH of Christ of Anoka

Year 2015-2016

To be completed by all participants. If the participant is a minor or not legally responsible for her/ himself, it must be SIGNED BELOW by a parent/guardian.

NAME:_____

STREET ADDRESS:_____

CITY:_____ **ZIP:**_____

HOME PHONE: ( )_____ **CELL PHONE: ( )**_____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ **GRADE LEVEL:**_____

PARENT/GUARDIAN or spouse (for emergency contact):_____

STREET ADDRESS:_____

CITY:_____ **ZIP:**_____

EMAIL ADDRESS: _____

PHONE #'S: HOME ( )_____ **CELL ( )** _____ **WORK ( )** _____

SECOND EMERGENCY CONTACT:_____

STREET ADDRESS:_____

CITY:_____ **ZIP:**_____

PHONE #'S: HOME ( )_____ **CELL ( )** _____ **WORK ( )** _____

HEALTH INSURANCE COMPANY:_____**POLICY #**_____

GROUP #:_____ **POLICY HOLDER NAME:**_____

PARTICIPANT PHYSICIAN:_____ **PHONE: ( )**_____

Is participant in good health and able to participate in normal activities? YES_____ NO_____

Please explain any special dietary needs and/or health:_____

Current Medications:_____

Please note that any over the counter or prescription medications must be given to a youth leader for safe storage on any off-site trips/events. Place medicine in zip lock bag along with a youth's name and a signed note explaining dosage

Any Allergies:_____

Allergies to Medications:_____

OVER-->

Please mark any that apply:

_____ Hay fever	**_____ Convulsions**	**_____ Epilepsy/Nervous disorder**
_____ Asthma	**_____ Heart Condition**	**_____ Frequent Stomach Upsets**
_____ Bleeding	**_____ Physical Handicap**	**_____ Insect Sting Allergies**
_____ Fainting	**_____ Hyperventilation**	**_____ Any Major Illness in past year**
_____ Diabetes		

If any of the above are checked, please give details (i.e. include normal treatment of allergic reactions):

_____

_____

_____

_____

Date of last tetanus shot:_____

Contact Lenses: YES_____ NO___

Any additional health information:_____

_____

_____

_____

_____

EMERGENCY TREATMENT AUTHORIZATION:

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I cannot be reached in an emergency during Youth Group activities, I hereby give my permission to the physician or dentist selected by the activity leader to hospitalize, to secure medical treatment and/or to order an injection, anesthesia, or surgery for my child if deemed necessary.

I understand that my insurance coverage (or my insurance coverage for my child) will be used as primary coverage in the event medical intervention is needed.

_____ _____

Parent/Guardian Signature **Date**