



# Health Form

## Holston Conference UMC Youth Ministry

Name \_\_\_\_\_

Event \_\_\_\_\_

Date \_\_\_\_\_

**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): \_\_\_\_\_

Family Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Subscriber's Name: \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_ S.S.#: \_\_\_\_\_

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

**Signature of parent/guardian or adult participant:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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 give permission for the participant to receive the following over-the-counter medications according to the specific directions on the product label unless otherwise directed by a physician.

| <u>Symptom</u>                     | <u>Medication</u>                                   |
|------------------------------------|---|
| Headache, Fever                    | Acetaminophen (Tylenol) _____                       |
| Cramps, Muscle Pain, Inflammation, | 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.

List any 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:**

- Will participant be leaving the event for any period of time and returning to the event? \_\_\_\_\_  
Day and time of departure: \_\_\_\_\_ Day and time of return: \_\_\_\_\_  
Person authorized to pick up participant from the event: \_\_\_\_\_
- Will participant be picked up early on the last day of the event? \_\_\_\_\_ If so, what time? \_\_\_\_\_
- Who will pick up participant on the last day of event? \_\_\_\_\_

**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