

HEALTH FORM

Please Print

Name of Youth _____ Date of Birth _____

Address _____ City _____ Zip _____

Home Phone (____) _____ Sex _____

Parent (s) Name _____

Address (if different from student) _____

Home phone _____ Work number mother) _____ (father) _____

Cell phones _____

Alternate emergency contact: Name _____ Phone _____

Health Insurance information: **Include a copy of the health insurance card**

Name of company _____

Policy number _____ Group number _____

In whose name is the insurance _____ Hospital Preference _____

Family doctor _____ Phone _____

Health History:

Medical conditions we need to know: _____

Allergies: _____

Present Medications _____

wear contacts? Yes No Date of last tetanus _____

List any Health/medical conditions or food allergies:

List over the counter medications that can be given to your child if needed:

I understand that in the event a medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I (we) cannot be reached, I give my permission for medical treatment to the physician or dentist selected by the adult leaders of the United Methodist Church.

I understand that my insurance coverage will be used as primary coverage in the event a medical emergency occurs.

I understand that transportation to away activities will be provided by the church staff and volunteers. I understand all reasonable safety precautions will be taken at all times by the church and its agents during the events and activities. I agree not to hold the church leaders, employees and volunteer staff liable for damages, losses, diseases, or injuries incurred.

Parent Signature _____

Date _____

For promotional and publicity purposes, I will allow my youth's picture to be taken and used.

Parent Signature _____ **Date** _____