

HEALTH INFORMATION & EMERGENCY CONTACT INFORMATION

Name of Youth: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Names: _____

Parent/Guardian Cell Phone Number: _____ Work Number: _____

Emergency Contact Information (in the event we cannot contact a parent or guardian)

Name: _____ Relation: _____ Phone Number(s): _____

Name: _____ Relation: _____ Phone Number(s): _____

Physician's Name: _____ Phone Number: _____

Medical Insurance Provider: _____ Policy Number: _____

Important Health Information (If Yes, please provide an explanation by writing on the back of this page).

- | | | |
|---|------------------------------|-----------------------------|
| Does the youth participant have a pre-existing medical condition? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is the youth participant currently taking any drugs or medications? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the youth participant have heart conditions? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the youth participant have high blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has the youth participant been diagnosed with diabetes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has the youth participant been diagnosed with asthma? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has the youth participant been diagnosed with mononucleosis in the past 12 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the youth participant experience fainting or motion sickness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the youth participant have any allergies (food, bees, insects, medicines)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you foresee any problem with the youth participating in physical activities? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is the youth participant restricted from eating certain foods or participating in certain activities? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has the youth participant had any recent injury, illness or infectious disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the youth participant wear glasses, contacts or protective eye wear? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is the youth restricted from eating certain foods or participating in certain activities? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the youth have a disability (physical, intellectual, emotional)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

* If yes, use the back of this page to indicate the functional implications and any concerns about participation related to the disability.

Please use the reverse side of this two page form to include any additional information related to the youth participant's health, special restrictions or considerations the youth advisors may need to be aware to assist us in providing safe and healthy activities for all children.

Medications Being Taken

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Any medications the participating youth must take during a youth group activity must be included on this form. The youth participant must provide the medication to the youth group advisor at the beginning of the activity in its original container, identifying the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. The youth group advisor will retain custody of the medication until which time the youth notifies the advisor, at which the youth will be permitted to take the medication. Whenever a question regarding medication arises, the youth participant’s parent/guardian will be notified.

Please identify any and all medication the youth participant, the dosage and the schedule for which it should be taken:

<u>Medication</u>	<u>Dosage</u>	<u>Schedule</u>

I give my permission for the youth participant to be provided the following using manufacturer’s instructions:

- | | | | |
|-----------------------------|--|----------------------------|--|
| Acetaminophen (Tylenol) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diphenhydramine (Benadryl) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ibuprofen (Advil, Motrin) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Antacid (Rolaids, Tums) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Topical Antibiotic Ointment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sunblock/Solarcaine | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Parent/Guardian Acknowledgment & Consent

I acknowledge that there is the possibility of bodily injury whenever youth travel and participate in recreational activities. To the best of my knowledge, the above named youth participant is in good health and capable of extended physical activities. I have read and understand the information in the Youth Group Program Guide, including the Health Information & Emergency Contact Information Form, and understand all the information it contains. I further agree to notify the youth group advisors in writing if I become aware of any of the above permissions or information about my son, daughter or child in my custody has changed. I understand that engaging in any youth group activity is a personal choice and completely voluntary, and I authorize the person whose name appears above to participate in youth group activities.

Parent/Guardian’s Signature

Parent/Guardian Name (Please Print)

Date