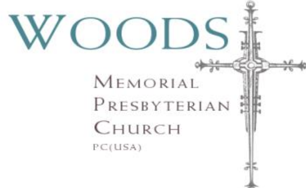

MEDICAL INFORMATION

Youth and Their Families Ministry

Participant Name: ____Date of Birth: ____________ Age: ________

Emergency Contact Name: ____ Relation: ______________________

Emergency Contact Phone: (_______) ________-___________

Physician's Name: ____

Physician's Phone: (_______) ________-___________
Do you have medical insurance? [ ] yes [ ] no

Please make a copy of your insurance card and attach with form

I/we give our daughter/son permission to receive full medical care in case of an emergency, and I/we assume full responsibility for all medical bills, if any. I give permission to the staff and adult youth leaders of Woods Memorial Presbyterian Church to authorize medical care for my daughter/son and to provide individual transportation to receive care. I/we also agree to hold harmless and indemnify Woods Presbyterian Church, its directors, employees or agents, for any liability by said church as the result of negligent, willful or intentional acts of said participant, including expenses incurred attendant thereto.

NOTE: Prescription drugs, as indicated on page 2 of the youth's medical form, will be held by a designated adult volunteer who will maintain possession of the medication until requested by the youth. It will be the youth's responsibility to self-administer prescription medication. The designated volunteer will exercise discretion when providing youth with required medication.

Participant Signature: ____ Date: ____/____/2019

Parent Signature:____ Date: ____/____/2019

TO BE COMPLETED BY HEALTH CARE PROVIDER

(Required for Youth Summer Trip Registration)

Please have this completed and signed by a certified and licensed physician, nurse practitioner or physician assistant

I certify that I have reviewed the health information of the participant and find no contraindication for participation in Woods Youth Ministry activities and/or summer trips.

Provider Signature: ____ Date: ____/____/2019

Office Address: _____________________________________ Office Phone: (_______) ________-__________

Revised 12/2018

Name: ___________________________________ Male/Female: _____ Age: _____ Height: _____ Weight: ________
Date of last TETANUS shot: ______________

My child can be given the following over-the-counter medications by request:

[ ] Tylenol (acetaminophen)　　[ ] Advil (ibuprophen)　　[ ] Lotions/gels/creams for sunburn, bug bites, poison ivy exposure, etc
[ ] Antacids (Tums, Mylanta)　　[ ] Antihistamine or decongestant

Health History: Do you currently have or have you ever been treated for any of the following?

YES	**NO**	**CONDITION**	**EXPLAIN**
		Are you currently under a doctor's care?	
		Allergies	
		Food, insect bites, plants	
		Medication	
		Seasonal allergies	
		Health Conditions	
		Abdominal/digestive problems	
		Asthma Do you carry an inhaler?	
		Ankle/Knee/Leg problems	
		Behavioral/neurological disorders	
		Diabetes	
		Dislocations/Sprains	
		Fainting Spells	
		Heart Disease	
		Hypertension (high blood pressure)	
		Psychiatric, psychological or emotional difficulties	
		Seizures Last Seizure: / /	
		Sleep Disorders	
		Surgery Last Surgery: / /	
		Do you have any other condition that might limit your activities or affect your health or the wellbeing of others?	

Medications (List all medications currently used. If additional space is needed, attach a list containing the information shown below. Epi-pens and inhalers must be included even if they are for occasional or emergency use only.)

[ ] No Medications　　[ ] Additional Medications

Medication: ____________________	Medication: ____________________	Medication: ____________________
Dose/Frequency: ________________	Dose/Frequency: ________________	Dose/Frequency: ________________
Reason: _______________________	Reason: _______________________	Reason: _______________________