St. Paul's United Church of Christ
Youth Health History Form

The Health History Form is to be completed and signed by a parent/guardian and Student
(For Youth Ministry/Confirmation Use Only)

Full Name: _____ DOB:_____

Parents' Name(s): _____

Address: _____

City, State & Zip: _____

Phone Numbers:

Home: _____ Teen's Cell: _____ Parent's Cell _____

Teen's Email: _____

Parent's Email: _____

Family Insurance Carrier: _____ Policy/Group #: _____

Name of Family Physician: _____

Physician's Phone: _____ Exchange #: _____

****Please include a copy of the front and back of insurance card(s).****

IN CASE OF A MEDICAL EMERGENCY, I understand that when medically feasible, an effort will be made to contact a parent or guardian, but in the event one is not reached or it is not medically possible to contact me, I hereby give permission for my son/daughter to be treated.

_____ _____
Signature of Parent/Guardian Date

In the event consent is needed for medical care on a non-emergency basis or for other matters and I cannot be reached, the following person is authorized to act on my behalf.

Name: _____ Phone: _____

Address: _____ Relationship: _____

_____ _____
Signature of Parent/Guardian Date

I hereby grant permission for nonprescription medication (such as Advil, Tylenol, throat lozenges, cough drops) to be given to my teenager, in the event circumstances reasonably demonstrate that my teen is in need of such drugs.

_____ _____
Signature of Parent/Guardian

I relieve St. Paul's United Church of Christ of all responsibility and consequences that may arise as a result of this treatment. I will not hold St. Paul's United Church of Christ, SPUCC staff, volunteers, or representatives associated with the youth ministry liable in the event of injury. Further, I agree to accept any and all financial responsibility as a result of scheduling medical treatment. My child agrees to abide by all the rules and regulations stated. I understand that SPUCC will not be liable if my child fails to cooperate with regulations, and that any infractions of the rules may result in immediate dismissal.

Parent Signature: _____ Date:_____

Teen's Signature: _____ Date: _____

Part I

Immunizations

Are your child's immunizations current: Yes No

If "No", please explain: _____

Date of last Tetanus Immunization: _____

Date of your child's last examination: _____

Part II

Allergies (Specify causal agent and nature of reaction—e.g. penicillin causes hives): _____

_____

_____

What action should be taken: _____

_____

_____

Part III

Other health conditions (check only those that apply)

_____ Emotional Disturbances	_____ Fainting	_____ Special Dietary Regiment
_____ Hearing Impairment	_____ Motion Sickness	_____ Nosebleeds
_____ Eating Disorders	_____ Frequent Headaches	_____ Other (Specify) _____

_____

Please explain. Indicate any information useful to the adult in charge in relation to any of the above health conditions. Indicate any activity to be encouraged or restricted _____

_____

_____

Part IV

Illness and Injuries (check those that apply)

Chronic or recurring illness: _____

_____ Asthma _____ Seizures _____ Heart Disease/Defect

_____ Kidney Disease _____ Hypertension _____ Musculoskeletal Disorders

_____ Diabetes _____ Bleeding/Clotting Disorder

Other (Specify) _____

_____

Yes No Were any complicating medical problems noted in your child's last examination?

Yes No Is your child currently under a physician's care for medical problem(s)?

Since your child's last health exam, have they had:

Yes No a serious injury requiring medical attention?

Yes No medication prescribed by a physician to be taken on a regular basis?

Yes No a surgical operation or fracture?

Yes No any restrictions concerning physical activities?

Please explain any "yes" answer to the above questions. Include dates: _____

_____

_____