

Health Form

ST. PAUL LUTHERAN CHURCH, MILFORD CENTER, OHIO

Name: _____
 Birth date: ____/____/____ Age: ____ Grade: ____ Gender: ____
 Address: _____
 Phone: (H) _____ (C) _____
 Parents'/Guardians' Names: _____
 Phone: (H) _____ (C) _____

IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY

Name: _____
 Relationship: _____ Phone: (H) _____ (C) _____
 Doctor: _____ Phone: _____
 Dentist: _____ Phone: _____
 Pharmacy: _____ Phone: _____

NAME OF FAMILY MEDICAL/HOSPITAL INSURANCE

Insurance Carrier: _____ Policy Number: _____
 Primary Insured's Name: _____ Insurance Phone: _____
 Activity restrictions by parent's/physician's advice: _____
 Other information we need to know: _____

ALLERGIES – Circle all that apply

Hay Fever Poison Ivy Insect stings Food: _____
 Asthma Penicillin Other Drugs: _____

Medications brought to event: _____
 Notes on giving: _____

The following medications may be administered to my child, as needed, by designated chaperones:

Acetaminophen Ibuprofen Antacids Anti-diarrhea medication

Special considerations: _____

AUTHORIZATIONS

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed event activities except as noted above. I also give permission to the event coordinator or chaperone to order x-rays, routine tests and treatment. In the event I cannot be reached in an emergency, I give permission to the physician selected by the event coordinator to transport, hospitalize and secure proper treatment, order injection and/or anesthesia and/or surgery.

Signature: _____ Date: ____/____/____