Our Savior Lutheran Ministries

Youth Ministry Health Form (September 2024-August 2025)

Name of student_____ Date of birth _____ Sex _____

Address _____ City _____

State_____ Zip_____ Phone # (_____) _____

Emergency Contact Person:

Parent/Guardian name(s) _____

Address (if different from above) _____

City _____ State_____ Zip _____

Phone # (Home)(_____) _____ (Work)(_____)_____

(Cell) (_____)_____

Alternate Contact Person (Use someone near the primary contact)

Name _____ Phone # (Home) (_____)_____

(Work) (_____)_____ (Cell)(_____)_____

Address_____ City _____

State ____ Zip _____

Medical Information

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while your child is at the activity.

Do you have health insurance? Yes☐ No ☐

Name of insurance company _____

Policy # _____ Group # _____

In whose name is the insurance? _____

Family doctor _____ City _____

Phone # _____

If your child should require medical attention for injuries received or illnesses contracted prior to activity, please send us the necessary information to give him or her proper medical care during his or her time with the youth ministry activity.

Health History

List any pre-existing or present medical conditions:

List name and dosage of any medications that must be taken:

Any allergies?☐ To medications?☐ hay fever☐ heart condition☐

diabetes☐ insect stings☐ epilepsy/nervous☐ asthma disorders☐

frequent upset stomach☐ physical handicap☐ dietary restrictions☐

Any major illnesses during the past year?☐

If any of the above are checked, please give details (for example, include normal treatment of allergic reactions)

Date of last tetanus shot_____ Contact lenses? ____

Any activity restrictions? yes☐ no☐ What?_____

Parental Medical and Liability Release Statement

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I cannot be reached in an emergency during the activity dates shown on this form, I hereby give my permission to the physician or dentist selected by the activity leader to hospitalize, to secure medical treatment, or order an injection, anesthesia, or surgery for my child as deemed necessary.

Parent/Guardian Signature_____ Date _____