CONFIDENTIAL

Health Form

St. Paul Lutheran Church, Mount Vernon, Iowa

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: _____/_____/_____