

Our Savior Lutheran Church
1910 Black Road
Joliet, IL 60436
YOUTH HEALTH FORM FOR ALL ACTIVITIES

This information is good for one year from date notated by parent, guardian or legal adult.

*******Include with this information a copy of your insurance card.**

This information will be kept in a secure place at the church office for use with all Youth activities.

This information will be taken with Youth leaders on all Youth activities.

DATE COMPLETED _____

** I, hereby give my permission to the adult leadership to act on my behalf in case of an emergency. I, hereby give my permission to the licensed physician selected by the activity leadership, to order and/or administer proper treatment and medical care, routine tests, X-rays, anesthesia, injections, surgery, and/or secure hospitalization for my child named on this form and to release necessary medical information for insurance purposes. In the event of an emergency, activity leadership will make every effort to reach the parents as soon as possible.

****Signature of Parent/Guardian:** _____ **Date:** _____

Youth's Name _____ Nickname: _____
Date of Birth _____ Age: _____ Gender: _____
Street address: _____
City, State, Zip Code: _____
Home Phone# _____

E-MAIL ADDRESS WHERE INFORMATION REGARDING CHURCH YOUTH ACTIVITIES/INFORMATION MAY BE COMMUNICATED: _____

****Parent Contact Information:** We will call in an emergency. Provide contact information for at least 3 people who know your child that we may contact. We will make every effort to reach the parents first.

Dad's Name: _____ Mom's Name: _____
Dad Cell #: _____ Mom Cell #: _____
Dad Daytime #: _____ Mom Daytime #: _____

Alternative #1: _____ Alternative #2: _____
Daytime #: _____ Daytime #: _____
Evening #: _____ Evening #: _____
Cell #: _____ Cell #: _____

Insurance Information:

Primary Youth Health/Accident Insurance Company _____
Policy # _____ Group # _____

Secondary Health/Accident Insurance Company _____
Policy # _____ Group # _____

Health Care Provider Information:

Name of child's physician: _____
Clinic name and city: _____ Phone #: _____

Name of child's dentist/orthodontist: _____
Clinic name and city: _____ Phone #: _____

Name of (other) physician: _____
Clinic name and city: _____ Phone #: _____

****HEALTH HISTORY: Please complete the following. The information provided will be used at all Youth related activities in conjunction with Our Savior Lutheran Church, including JYF, LYF, retreats, lock-ins, and other outings.**

***Allergies: Check all that applies.**

My child has no known allergies

My child has the following allergies (please list ALL allergies, including food, medication, insect, substance, latex, bee stings or seasonal....describe, please be specific) Describe reaction, and what is done to manage it:

***Diet: Check all that apply.**

My child has no restrictions.

My child has the following dietary restriction(s) (please be specific):

***Health Concerns for Youth:** Check if youth has or is subject to. Write in any health concerns not listed below.

Asthma Fainting Spells Convulsions Heart Trouble Diabetes

Blood Disorder ADHD or ADD Headaches Bronchitis

Provide information about supportive health care needed for each checked item:

None of the above applies: Other _____

***Has Difficulty with:** Check if youth has or is subject to

Sleepwalking Bedwetting Breathing Eyes, ears, nose, throat Digestion

Does your child wear Glasses Contacts?

****Tetanus Booster:** (please list month and date of last shot) _____

***Medication: Provide complete information. Please update information if it changes throughout the year.**

My child does not take any medication on a regular basis.

My child takes routine medication as follows

Please have an adult administer all medications My child can self-medicate

Name of Medication: _____ Name of Medication: _____

Reason for taking: _____ Reason for taking: _____

Dose taken: _____ Dose taken: _____

Time(s) of day? _____ Time(s) of day? _____

(attach additional information if necessary)

***Any restrictions of activity for medical reasons? EXPLAIN:**

***Authorization for Routine Health Care:** My child is allowed to take/use the following medications under the supervision of an adult leader:

Tylenol Advil Benadryl Pepto Bismal Antacids Antibiotic Ointment

*****Parent/Guardian Signature:** _____ **Date:** _____

*Activity leadership is authorized to perform **Basic First Aid/CPR** as deemed necessary.

PLEASE LIST EXCEPTIONS or SPECIFIC REQUESTS: _____

***Parent Authorization:** This health history is correct as I know, and the youth herein described has permission to engage in all prescribed activities, except as noted by me. _____

*****THIS HEALTH HISTORY IS CORRECT SO FAR AS I KNOW.**

*****Parent/Guardian Signature** _____ **Date:** _____