UCUCC YOUTH PROGRAM HEALTH FORM 2017-18

A completed and signed health form must be on file for all youth program participants. This form is to be completed by the parent/guardian. Please notify Margaret Irribarra if any of this information should change or need to be updated.

Youth's Name _____ Grade for 2017-2018 _____
Gender: F / M / Trans / Other _____ Birth date_____ Height_____ Weight ___
Parent's/Guardian's name/s:_____
Work phone_____ Cell phone_____ Home Phone_____

In case of emergency, notify _____ Relationship _____
Home Phone (_____)_____ Work Phone (_____)_____
Cell Phone (_____)_____

Insurance and Physician Information
Participant's insurance company _____ Insurance policy number _____
Insurance company address and phone _____
Name the coverage is in _____ _____ Date of Birth of the Primary insured _____
Participant's physician _____ Phone (_____)_____

Swimming Ability: ☐ doesn't know how to swim ☐ poor ☐ fair ☐ good ☐ excellent

Immunizations (Please give month/year) Tetanus ___ / ___ Polio ___ / ___ DPT ___ / ___ MMR ___ / ___
Meningitis ___/___ Hepatitis B ___/____

Allergies (Please check yes or no)
Hay fever ☐ Yes ☐ No Penicillin ☐ Yes ☐ No Sulfa ☐ Yes ☐ No Other drugs ☐ Yes ☐ No
Bee sting ☐ Yes ☐ No Poison ivy/oak ☐ Yes ☐ No Foods ☐ Yes ☐ No Other _____
►**please explain reaction:** _____

Dietary information:
Vegetarian ☐ Yes ☐ No Special dietary needs _____
Any special diet instructions? _____
Any **food allergies**? _____

Has the youth experienced any major life event that might impact his/her experience in youth group or on retreats?
IF YES, PLEASE EXPLAIN (you can use another sheet of paper if needed):
_____
_____
_____

Health Concerns (Please check yes or no)

Asthma	☐ Yes ☐ No	Skin condition	☐ Yes ☐ No	Sleep walking	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Colds	☐ Yes ☐ No	Ear, nose, throat	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No	Joints	☐ Yes ☐ No
Cramps	☐ Yes ☐ No	Hyperventilation	☐ Yes ☐ No	Convulsions	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Heart disease	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Acne	☐ Yes ☐ No	ADHD/ADD	☐ Yes ☐ No
Bed Wetting	☐ Yes ☐ No	Behavior Concerns	☐ Yes ☐ No	Learning Difficulties	☐ Yes ☐ No		

Other _____

- continues on p.2 ➔ ➔ ➔ ➔

Name of Participant: _____

► Please explain any of the above "Yes" responses or any other physical or emotional challenges _____

_____

_____

Is the participant in general good health and able to participate in all normal activities? □ Yes □ No
Please explain any restrictions _____

Special needs: ADA room_____; large print_____; signing_____; hearing device_____;

Current Medications

MEDICATION	DOSAGE	SCHEDULE	REASON
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Can your youth be expected to take the right amount of medication at the proper time? Yes No
► If you give your youth permission to administer his/her own medication, please sign here:

_____ _____
print name sign name

(**If the answer is no**, **permission to administer must be given to the youth minister/s traveling with your youth.**)

Please send medications in their original containers. Send only the amount needed, plus 2 extra doses. Do not send a huge supply.

Consent and Emergency Treatment Authorization:

I request and authorize the area hospitals, medical staff personnel, agents and employees, to have access to information contained in this form and to provide all medical care, routine tests and necessary transportation advisable for my health or the health of my child. I acknowledge that no representations, warranties or guarantees as to result or cures will be made. I hereby give permission to medical staff to secure and administer treatment including hospitalization

for myself _____(adult advisors)

or for my child, _____ (youth participants).

Signature of Parent/Guardian _____ Date _____

Signature of Adult Participant_____ Date _____

Please note: Over-the-counter or internally-administered medication of any kind including **Ibuprofen (Motrin/Advil)** and Tylenol (acetaminophen) will not be administered to minors in attendance at the events without express permission of the parent/ guardian or attending physician. Use the attached **Over-the-Counter Medication form** to give permission.

- continues on p.3 ➔ ➔ ➔ ➔

Over-the-Counter Medications

To treat symptoms that your youth might have while on the retreats or other youth events, we ask that you fill out the following table of over-the-counter medications which will be administered to your youth if he/she can take them. **These are for the occasional need and will be given only with parental permission below. We will stock a moderate supply of the items listed below**

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Important: All prescription medication must be sent in its original container.

Symptom	***Medication***	***Yes***	***No***	***Comments***
Cough	Robitussin			
Allergy/Stuffy Nose	Claritin Claritin-D			
Antihistamine for mild allergic reactions	Benadryl			
Fever, Headache, Pain	Tylenol Advil			
Diarrhea	Pepto-Bismol			
Constipation	Grape-nuts Applesauce			
Upset Stomach	Mylanta Tums			
Menstrual Cramps (f only)	Ibuprofen Tylenol			
Bug bites Poison Ivy	Calamine Caladryl			
Sunburn	Aloe			
Cuts, Scrapes	Neosporin			

List any other Over-the-Counter medicine that you do NOT want administered to your youth?

_____

Youth's Name _____ (PRINT CLEARLY, thanks)

Parent's/Guardian's Signature _____

Date_____

If you need more room for comments, please use the backside of this sheet.