UCUCC YOUTH PROGRAM HEALTH FORM **2018-2019**

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 Swanson if any of this information should change or need to be updated.

Youth's Name ________________________________ Grade for 2018-2019 _______
Gender Identity: 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 ____

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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.**)

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.

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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 may be administered to your youth if he/she/they 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.** If there are further needs beyond these, we will call you directly to check in.

Symptom	***Medication***	***Yes***	***No***	***Comments***
Allergy / Stuffy Nose	Claritin Claritin-D			
Antihistamine for mild allergic reactions	Benadryl			
Fever, Headache, Pain	Tylenol Advil			
Diarrhea, Upset stomach	Pepto-Bismol Tums			
Menstrual Cramps (f only)	Ibuprofen Tylenol			
Bug bites / Poison Ivy	Calamine Hydrocortisone			

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.