

Youth Groups Health Form 2009-2010
First Congregational Church, Cheshire, CT

Youth Information:

Name of Student _____ Date of Birth _____
Address _____ Age _____
Town _____ State _____ Zip _____
Youth's Home Phone (_____) _____ Sex _____
Youth's Cell Phone (_____) _____ Youth's Email _____

Emergency Contact Person / Parent Guardian Information:

Parent/Guardian Name _____
Address (if different from student) _____
Town _____ State _____ Zip _____
Parent's Home Phone (_____) _____ Parent's Work (_____) _____
Parent's Cell Phone (_____) _____ Parent's Email _____

Alternate Contact Person:

Name _____
Address _____
Town _____ State _____ Zip _____
Home Phone (_____) _____ Work (_____) _____
Cell Phone (_____) _____

If you have medical insurance, your carrier will be billed for medical charges incurred while your child is at the activity:

Name of Insurance Company _____
Policy Number _____ Group Number _____
In whose name is the insurance? _____
Family Doctor _____ Office Phone Number (_____) _____

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

Health History

Pre-existing or present medical conditions _____
Name and dosage of any medications that must be taken _____
List allergies (environmental / insect / medication): _____

Check all that apply:

- | | | |
|---------------------------------------------------------------|--------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emotional Disorders | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding / Clotting Disorders | <input type="checkbox"/> Frequent Stomach Upsets | <input type="checkbox"/> Migrain |
| <input type="checkbox"/> Diabetes or Hypoglycemia | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Physical Handicap |
| <input type="checkbox"/> Major illnesses during the past year | | |

If any of the above are checked, please give details (i.e., include normal treatment of allergic reactions)

Date (year) of last Tetanus Shot _____ Contact Lenses? Yes No

Any activity (i.e. swimming) restrictions? Yes No

Please describe: _____

If my youth requires medical attention while at a youth event and I and my alternate contact cannot be reached, I authorize the Youth Director or Adult Volunteer in charge to act on my behalf.

Parent/Guardian Signature: _____ Date: _____