

UCUCC YOUTH PROGRAM HEALTH FORM

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

Youth's Name _____ Grade for 2011-12 _____ Gender F / M

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	<input type="radio"/> Yes <input type="radio"/> No	Skin condition	<input type="radio"/> Yes <input type="radio"/> No	Sleep walking	<input type="radio"/> Yes <input type="radio"/> No	Depression	<input type="radio"/> Yes <input type="radio"/> No
Colds	<input type="radio"/> Yes <input type="radio"/> No	Ear, nose, throat	<input type="radio"/> Yes <input type="radio"/> No	Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Joints	<input type="radio"/> Yes <input type="radio"/> No
Cramps	<input type="radio"/> Yes <input type="radio"/> No	Hyperventilation	<input type="radio"/> Yes <input type="radio"/> No	Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Heart disease	<input type="radio"/> Yes <input type="radio"/> No	Fainting	<input type="radio"/> Yes <input type="radio"/> No	Acne	<input type="radio"/> Yes <input type="radio"/> No	ADHD/ADD	<input type="radio"/> Yes <input type="radio"/> No
Bed Wetting	<input type="radio"/> Yes <input type="radio"/> No	Behavior Concerns	<input type="radio"/> Yes <input type="radio"/> No	Learning Difficulties	<input type="radio"/> Yes <input type="radio"/> No		

Other _____

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.

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**

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.