

# PERSONAL HEALTH AND MEDICAL RECORD

**YOUTH NAME** \_\_\_\_\_

I give permission for full participation in St Paul Lutheran Youth programs, subject to limitations noted herein.

**In case of emergency**, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date \_\_\_\_\_ Signature of parent/guardian or adult \_\_\_\_\_

**(To be filled out annually by all participants)**

To be filled out by parent, guardian, or adult participant. Please print in blue or black ink.

**IDENTIFICATION**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Name of parent or guardian \_\_\_\_\_ Telephone \_\_\_\_\_

Parent Cell Phone: \_\_\_\_\_ Pager #: \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If person named above is not available in the event of an emergency, notify

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name of personal physician \_\_\_\_\_ Phone \_\_\_\_\_

Personal health/accident insurance carrier \_\_\_\_\_ Policy No. \_\_\_\_\_

Check all items that apply, **past or present**, to your health history. Explain any "Yes" answers.

**ALLERGIES:** Food, medicines, insects, plants Yes No Explain: \_\_\_\_\_

**GENERAL INFORMATION:** Circle those that apply:

ADHD (Attention-Deficit Hyperactivity Disorder)    Convulsions/seizures    Hemophilia    Asthma    Diabetes  
High blood pressure    Cancer/leukemia    Heart trouble    Kidney disease    Other \_\_\_\_\_

Explain: \_\_\_\_\_

Please list ALL medications/dosage taken regularly: \_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation in or playing strenuous physical games:

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: \_\_\_\_\_

## Media Waiver

I hereby give permission for my child to be filmed or photographed by St Paul Lutheran Church. My child's picture may be used for any media publication (TV, newspaper or the church web-site), I will not expect compensation.    \_\_\_\_\_ Yes    \_\_\_\_\_ No

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(This form to be kept on file in the church office during the year)

(If something changes during the year, parents are responsible to notify the church office of those changes)