

2017 HEALTH FORM

Today's Date ___/___/_____

This health form shall be good for the entire 2017 year. Once you have filled it out, please return it to the church.

SECTION 1: MEDICAL RECORD AND INSURANCE

Full Name: _____ Date of birth: _____

Address: _____

City/State/Zip: _____ Home phone: (_____) _____

MEDICAL INSURANCE INFORMATION

Is this person covered by a medical insurance policy? Yes _____ No _____

Name of policy holder: _____ Relationship to participant: _____

Insurance company: _____ Phone #: (_____) _____

Medical insurance policy number: _____ Check one: Group plan: _____ Individual/Family plan: _____

MEDICAL HISTORY

Blood Type: _____

List allergies or allergies to medications: _____

List medication(s) presently taking: _____

Please describe any medical problems or conditions including mental & emotional: _____

List any restrictions on sports or physical activity: _____

I hereby give permission for the person listed above to be treated with the following medications:

(Check medications you approve for this person to receive)

_____ Acetaminophen (temp/pain reliever) _____ Suphedrine (Sudafed/allergy) _____ Ibuprofen (temp/pain reliever)

_____ Diphenhydramine (Benadryl/allergy) _____ Loperamide (Antidiarrheal) _____ Guaifenesin (Robitussin/Cough Syrup)

List any medications person should not have: _____

Doctor's name: _____ Doctor's phone: (_____) _____

SECTION II: MEDICAL TREATMENT RELEASE AND LIABILITY RELEASE

I understand that Spark Youth Ministry/ North East United Methodist Church and its staff are committed to providing safe, fun and educational activities, and that all youth activities are conducted in a smoke-, alcohol-, and drug-free environment. In light of this, and to help ensure the safety of all concerned, I understand that if my child is in possession of drugs, alcohol or tobacco products, engages in any illegal conduct or refuses to follow the directions of the youth ministry staff or volunteers while participating in this activity, I will be telephoned to immediately to pick up my child.

In the event of a medical emergency, I declare that I am the child's parent or legal guardian and hereby authorize the Spark Youth Ministry staff, as agents for me, to consent to X-ray exams, and other medical, dental or surgical diagnosis and treatment, advised and supervised by a physician, surgeon or dentist. This authorization extends to any emergency room treatment, and admission and treatment as inpatient, considered necessary by the attending physician. I understand that, in the event of such an emergency, I will be contacted as soon as possible. It is my understanding that payment of any and all medical or dental bills will be paid by me the parent/ legal guardian or insurance company.

Signature of Parent, Guardian, or self if 21 or over

Name of Parent, Guardian, or self (printed)

Person to call in case of emergency

(_____) _____
Emergency phone number

Alternate person to call in case of an emergency

(_____) _____
Alternate emergency phone number

2017 INFORMATION FORM



Student's Name: _____

School Name: _____

Name of person(s) student primarily resides with _____

Youth Cell # _____ Text Yes or No

E-mail: _____

Parent/Guardian Info

Name: _____

Address (if different that Youth's): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Text Yes or No

E-Mail: _____

Name: _____

Address (if different that Youth's): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Text Yes or No

E-Mail: _____

Cecil County, MD/ Newark, DE; Pictures & Video Permission Slip

I give permission for my student to participate in any activity that Spark Youth Ministry may do in Cecil Country, Maryland or Newark, Delaware. Such as go to a restaurant, etc. Also I give permission for NEUMC to post photos & Videos of my student on the church website, bulletin board or that my be shown at the church.

Parent/Guardian Signature: _____