NORTHERN HILLS UNITED METHODIST CHURCH 2016

THIS FORM MAY BE PHOTOCOPIED WHEN COMPLETED. PRINT CLEARLY. USE BLACK INK.

NAME_____ _____ _____ _____
Last First Middle Home phone

ADDRESS_____ **CITY**_____ **ZIP**_____

____/___/ ___ _____ _____ **Youth Cell Phone**_____
Date of Birth Grade School

_____ _____
Youth's Doctor /Clinic Doctor's Phone

Date of Last: Health Exam _____ _____T.B. test

SHOT RECORD: _____Hepatitis A _____Hepatitis B _____Tetanus Shot

_____ _____ _____
Father's Name Work Phone Cell Phone

_____ _____ _____
Mother's Name Work Phone Cell Phone

_____ _____ _____ _____
Alternate Emergency Contact Name Day Phone Evening Phone Relationship

HEALTH HISTORY: (CHECK THOSE THAT APPLY)

DRUG ALLERGIES: _____

_____

OTHER ALLERGIES: ____Animals ___Food ___Insect stings ___Plants ___Pollen ____ Other
If any checked please explain: _____

_____

CHRONIC OR RECURRING ILLNESS:

___Ear infections ___Contact lens wearer ___Heart defect/disease ___Seizures ___Bleeding disorder

___ Asthma ___Diabetes ___Other (specify) _____

_____

SURGERIES, INJURIES OR OTHER HEALTH ISSUES: _____

_____

IN THE LAST YEAR: (ANSWER YES OR NO)

Have you been out of the USA in the last year? _____

Complicating medical problems/operations? _____ Serious injury/illness requiring medical care? _____

Please explain: _____

_____

SPECIFIC INSTRUCTIONS CONCERNING MY CHILD'S CARE: _____

_____

_____

_____

HOSPITAL INSURANCE INFORMATION: * *Please attach photocopy of insurance card*

_____

Name of Carrier Policy Number Group Number

_____

Insured's Name

_____

Company Name (if insured through employer)

FAMILY MEMBER (S) WHO MAY BE CONTACTED IN CASE OF EMERGENCY TO AUTHORIZE TREATMENTS:

_____

Name Day Phone Evening Phone Relationship

_____

Name Day Phone Evening Phone Relationship

MEDICAL TREATMENT AUTHORIZATION

I (we) understand that in the event the child named above is injured while in the care of Northern Hills United Methodist Church and requires the attention of a doctor, the Director of Student Ministries, and/or representatives of Northern Hills United Methodist Church will make every effort to contact us. If I (we) cannot be reached by telephone at one of the numbers listed above, or if because of an emergency, there is not time or opportunity to make a telephone call, I (we) hereby authorize the Director of Student Ministries, and/or representatives of Northern Hills United Methodist Church to give consent on my (our) behalf for emergency medical treatment. In the event that it becomes necessary for a representative of Northern Hills United Methodist Church to give consent on our behalf they are authorized:

1. To have access to any and all medical and related information and records.
2. To disclose medical and related information to others.
3. To employ and discharge medical and related personnel.
4. To consent or refuse consent to medical care and emergency medical procedures.
5. To provide appropriate relief from pain.
6. To arrange for care and lodging in a hospital.
7. To grant releases to health care professionals or institutions to assure that the wishes of the parent/guardian are fulfilled.
8. To take immediate physical custody and possession of the child that is the subject of this authorization in the absence of the ability of the parent/guardian to do so, and to provide for the care and physical custody thereof during such absence.

_____ _____

Parent Signature Date