

# HEALTH PERMISSION FORM FOR YOUTH ACTIVITIES

(Please Print)

NOTE: This form need only be updated once a year unless health or insurance information has changed.

Name of Youth \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Social Security Number \_\_\_\_\_

Parent(s) Name \_\_\_\_\_

Address (if different from student) \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work (mother) \_\_\_\_\_ Work (father) \_\_\_\_\_

Cell Phones \_\_\_\_\_

Alternate Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_

## Health Insurance Information: INCLUDE A COPY OF THE HEALTH INSURANCE CARD

Name of Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

In Whose Name is the Insurance \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

## Health History:

Medical Conditions We Need to Know \_\_\_\_\_

Allergies \_\_\_\_\_

Present Medications \_\_\_\_\_

Wear Contacts? Yes No Date of Last Tetanus \_\_\_\_\_

I give permission for my youth to participate in the activities sponsored by Living Word United Methodist Church including transportation to and from when necessary.

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I (we) cannot be reached, I give permission for medical treatment to the physician or dentist selected by the adult leaders of the church.

I understand that my insurance coverage will be used as primary coverage in the event of a medical emergency.

I understand all reasonable safety precautions will be taken at all times by the church and its agents during the events and activities. I agree not to hold the church leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

For promotional and publicity purposes, I will allow my youth's picture to be taken and used.

Youth's Name \_\_\_\_\_

Please let us know what over-the-counter medications/treatments you would like for us to use with your child if they become ill or hurt while at a youth function. Please put a check of x in the "yes" or "no" box.

Medicine	Yes	No	Medicine	Yes	No
Eye saline drops			Hydrocortisone anti-itch cream		
Throat lozenge			Ear-drying drops		
Cough drop			Pepto-Bismol or equiv.		
Tylenol or generic equiv.			Anti-diarrhea medicine		
Advil or generic equiv.					
Aspirin					
Triple antibiotic ointment					
Benadryl (for allergic reactions)					
Calamine lotion					

Are there any additional prescription or medicine allergies:

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Additional important health information:

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\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date