

CHILD HEALTH HISTORY / EMERGENCY MEDICAL AUTHORIZATION FORM

To be filled out by parent/guardian. Return Form to Assistant Rector on or before Sept. 1. Must be updated yearly or as changes occur.

Child's Name (first, middle initial, last): _____

Birth Date: ___/___/___ Age: _____ School attending: _____ Grade: _____

Home address: _____

City: _____ State: _____ Zip: _____ (Phone: _____)

Parent or Guardian Phone: Day _____ Cell _____ Evening _____

Home Address: Home address: _____

City: _____ State: _____ Zip: _____

2nd Parent or Guardian Phone: Day _____ Cell _____ Evening _____

Home Address: Home address: _____

City: _____ State: _____ Zip: _____

Child is in the custodial care of (circle one): both parents mother only father only other

Emergency Contact: If neither parent/guardian is available in an emergency, contact:

Name: _____ Relationship _____

Phone: Day _____ Cell _____ Evening _____

Health History: (Check all that apply and give approximate dates. Attach additional sheets as necessary)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> ADD/ADHD _____ | <input type="checkbox"/> Fainting _____ | <input type="checkbox"/> Nervous system _____ | Allergies: |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Frequent Colds/Sore Throats _____ | <input type="checkbox"/> Sickle Cell Anemia _____ | <input type="checkbox"/> Animals _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hay Fever _____ | <input type="checkbox"/> Sinusitis _____ | <input type="checkbox"/> Bee/wasp stings _____ |
| <input type="checkbox"/> Athletes Foot _____ | <input type="checkbox"/> Headaches; Migraines _____ | <input type="checkbox"/> Skeletal disease/disorder _____ | <input type="checkbox"/> Plants, ivy/oak _____ |
| <input type="checkbox"/> Bleeding/clotting disorders _____ | <input type="checkbox"/> Hearing _____ | <input type="checkbox"/> Skin Conditions _____ | <input type="checkbox"/> Drugs _____ |
| <input type="checkbox"/> Bronchitis _____ | <input type="checkbox"/> Heart defect/disease _____ | <input type="checkbox"/> Stomach upsets _____ | <input type="checkbox"/> Foods _____ |
| <input type="checkbox"/> Constipation _____ | <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Urinary Tract Infections _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Convulsions _____ | <input type="checkbox"/> Kidney Disease _____ | Wears: <input type="checkbox"/> Contacts <input type="checkbox"/> Glasses | |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Mononucleosis _____ | <input type="checkbox"/> Chicken pox _____ | |
| <input type="checkbox"/> Ear Infections _____ | <input type="checkbox"/> Motion Sickness _____ | <input type="checkbox"/> German measles _____ | |
| <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Muscle disease/disorder _____ | <input type="checkbox"/> Measles _____ | |
| | | <input type="checkbox"/> Mumps _____ | |

Are there any special needs or accommodations required? If yes, please explain _____

Are there any known behavioral and/or emotional problems? If yes, explain _____

Ever required any psychiatric counseling or hospitalization? If yes, explain _____

Operations or serious injuries _____

Disability or chronic or recurring illness _____

Activities to be encouraged or limited by her physician? _____

Dietary modifications _____

Has this person menstruated? _____

If not, has she been told about it? _____ If so, is her menstrual history normal? _____

Since her last health exam has your child had:

a serious injury requiring medical attention? _____ an illness lasting longer than one week? _____

an in-patient hospital treatment or the emergency room? _____

been restricted from participating in any school activities? _____

(Please explain any "YES" answers to the above questions and include dates and/or details. May use back of form if necessary.)

Immunization History:

Are all immunizations up-to-date? Yes No If no, please state reason _____

(Give date of immunization that the child listed above has had. DTP or DT (Tetanus) Date: _____)

Insurance Information:

Company: _____ Policy Number: _____

Policy Holder: _____

Company address: _____ City: _____ State _____

Other: Name of Dentist/Orthodontist: _____ Phone _____

Name of Physician: _____

Phone: _____ Date of last examination: _____

Preferred Medical Facility: _____ Location: _____

Medication Information:

Any prescribed medication being taken? No Yes - Inhaler Epipen Other- what, why, when, and dosage? _____

Current Weight _____ Current Height _____

My child may be given (check all that apply): Aspirin Benadryl Neosporin Tylenol None

IMPORTANT – THIS SECTION MUST BE COMPLETED

This health history is correct so far as I know. The person herein described has permission to engage in all activities except as noted. I hereby give permission to the Chaperone or Adult-in-Charge to provide routine health care and administer prescribed medications. I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my child's participation in any activity sponsored by St. Andrew's Episcopal Church. Should a medical emergency arise during my child's participation in a church-sponsored activity, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers I have given. If it is believed my child's life or health may be adversely affected by the delay

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that an attempt to contact me or my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied for trips and camping outside of the normal meeting place.

Signature of Parent/Guardian (in ink)

Date _____