

SPRINGDALE PRESBYTERIAN CHURCH/MEDICAL HISTORY FORM

(To be filled out by parent or guardian; PLEASE PRINT except for signatures)

YEAR 2011-2012

Date form completed _____

NAME _____ DATE OF BIRTH _____ AGE _____

PARENT OR GUARDIANS NAMES _____ HOME PHONE _____

ADDRESS _____ Zip _____ Email _____

Father: WORK PHONE _____ Mother WORK PHONE _____ Mother CELL _____ Father CELL _____

CHILD'S PHYSICIAN _____ PHONE _____

INSURANCE COMPANY _____ POLICY # _____

NAME OF INSURED _____ # _____ PHONE _____

List the name, address, and phone of another adult person who we can notify in case of an emergency, if you cannot be reached.

NAME _____ PHONE(S) _____

ADDRESS _____

PAST ILLNESS/DISEASES	APPROX. DATE	IMMUNIZATIONS/TESTS	APPROX. DATE
Frequent Colds		Diphtheria/Tetanus/Whooping Cough	
Frequent Stomach Upsets		Tetanus	
Frequent sore throats		Smallpox	
Kidney trouble		Polio	
Sinusitis		Typhoid	
Heart trouble		Hepatitis A	
Abscessed ear		Hepatitis B	
Rheumatic fever		MMR	
Bronchitis		Flu	
Convulsions		Schick	
Asthma		Tuberculin	
Tuberculosis		Previous injections of horse serum	
Diabetes		Other	
Hepatitis			
Chicken pox		OTHER:	COMMENTS
Measles		Behavior:	
Mumps		Night behavior (sleepwalking, bed-wetting, night terrors)	
Scarlet fever		Fainting	
Rubella		Menstruation	
Poliomyelitis		Constipation	
Whooping cough		Any contraindication to swimming or diving?	
HIV+/AIDS		Any activities to be restricted?	
Operations/other illnesses:		CURRENT MEDICATIONS:	
ALLERGIES:			
		PLANT ALLERGIES:	
		SUGGESTIONS FROM PARENTS:	

MEDICAL RELEASE FORM
SPRINGDALE PRESBYTERIAN CHURCH

SOCIAL SECURITY NUMBER OF CHILD

I grant permission for _____
(Print name of child/youth)

to participate and to travel with the Springdale Presbyterian Church (Louisville, KY) Youth Group to and from and during youth group activities and I understand that the group will be traveling by plane, bus, van or private automobile. I also authorize the adult leaders of Springdale Presbyterian Church Youth Group to act as my agent to consent to emergency transportation, examination, x-ray, anesthesia, injection, medical, dental, or surgical diagnosis or treatment and hospital care as advised and administered by any physician, dentist, or surgeon licensed to practice under the laws of the state where services are rendered, either at a doctor's office, clinic, or hospital. I understand that every attempt will be made to contact the parent or guardian in the event of an emergency. I, therefore, assume all responsibility for the decision so made, for the emergency care or treatment so secured for my child, and for the cost incurred. Also, I understand that some hospitals require notarized authorization before a child can be treated.

SIGNATURE OF PARENT/ GUARDIAN _____ DATE _____

Witness my hand and seal, this the _____ day of _____, Year _____.

SIGNATURE OF NOTARY:

OTHER COMMENTS ON CHILD'S/YOUTH'S HEALTH:

I give permission for my child's photograph/video to be used in church publications, projected media, church web page and emails.

Date _____ Signature of Parent/Guardian