YAP EVENTS

HEALTH INFORMATION FORM

(Please print legibly)

Minor's Name____

Address_________________________________City______________________State_____Zip Code__________

Date of Birth_______________Age_______ M/F_______ Church Affiliation______________________________________

Parent/Guardian's Name____

E-mail Address ____

Phone Numbers: Home______________________ Work ______________________ Cel______________________

Emergency Contact Person______________________________________ Relationship___________________________

Phone Numbers: Home______________________ Work ______________________ Cel______________________

Physician's Name_______________________________________ Office Phone Number___________________________

Insurance Company Name and Card # (attach photocopy of card) ____

****

ALLERGIES: Please indicate if your child is subject to any of the following allergies:

_____ Anaphylaxis _____ Penicillin _____ Hives _____Poison Ivy/Oak _____ Hay Fever _____ Asthma

_____ Rhinitis _____ Insect bites (bees, etc.) _____ Other [Please describe]: _________________________________

Food Allergies [Indicate what foods]:____

HEALTH CONDITIONS: Please indicate if your child has been treated in the last 12 months for:

_____ ADHD/ADD _____ Depression _____ Diabetes _____ Ear infections _____ Eating Disorders _____ Enuresis

_____ Epitaxis _____Herpes simplex _____ Migraines _____ Seizures _____ Syncope _____ Nose Bleeds

_____ Other conditions – temporary or chronic [Please describe]:____

____

Please list and explain any health condition which would limit participation in event activities:

____

____

____

____

____

MEDICATIONS

Please list all **prescription medications** your child takes and the reason the medication has been prescribed:

____

____

____

Please list all **over-the-counter medications** your child takes and the reason the medication is taken:

____

____

____

Please read the following carefully: All prescription medications and all over-the-counter medications will be supervised and administered by a responsible adult. All prescription medications must be in the container in which they were purchased. The name of the medication, the dosage, the times to be administered and the physician's name must be printed in the container. All over-the-counter medications must be in the container in which they were purchased. They will be used for your child only. Over-the-counter medications will be administered only for the conditions indicated on their containers.

TREATMENT

OVER-THE-COUNTER MEDICATIONS: Please read carefully and sign the following statement:

I give a responsible adult permission to administer any and all of the following over-the-counter medications as instructed on the medication container when needed and/or administer as I have indicated. I confirm that my child has no known allergy to the medications listed below.

Indicate **ONLY** those medications you wish **GIVEN**:

_____ Acetaminophen (325 mg) _____Acetaminophen (80 mg) _____Ibuprofen (200 mg) _____Bismuth

_____ Benedryl liquid _____ Benedryl Kapseals (25 mg) _____ Dimetapp Antihistamine/Nasal Decongestant

_____Ear Drops/Wax Softener _____Eye Irrigating Solution Ointment _____ Medicaine Swabs/Stingease

_____ Hydrocortisone Ointment/Corticool Gel _____ Calagel/Calahist/Aloe Vera _____ Orasol/Anesthetic

_____ Robutussin DM Gel _____ Cherry Eucalyptus Cough Drops _____ Triple Antibiotic

Signature of parent/guardian_______________________________ Date____________________

PERMISSION TO TREAT: Please read carefully and sign the following statement:

I understand that in case of emergency, every effort will be made to reach the parents/guardians or the emergency contact person of the youth. In the event that such contact is not possible, **I do give permission** for the responsible persons at the YAP Event to sign for emergency treatment for the child whose name appears on this form. I am willing to use my own insurance for any medical expenses which my child may require.

Signature of parent/guardian_______________________________ Date____________________