**TRINITY LUTHERAN CHURCH HEALTH FORM FOR YOUTH PARTICIPANTS**
**3701 Jefferson Avenue**
**Midland, MI 48640 (989) 631-0692**

**GENERAL INFORMATION**

NAME _____ BIRTHDAY _____

ADDRESS _____ SEX: F or M

CITY/STATE/ZIP _____

HOME PHONE _____ CELL PHONE(s)_____

PARENTS' NAMES _____

IN CASE OF EMERGENCY, CALL _____

HEALTH INSURANCE CARRIER NAME _____

GROUP OR ID #_____
***(Please provide a front/back copy of the health insurance card for reference)***

**HEALTH HISTORY**
List any special medical conditions that the staff should be aware of: _____

_____

List any recent illnesses / injuries / restrictions to physical activity for the participant _____

_____

List all allergies (food / drug / other) _____

Are all immunizations current? _____yes _____no (explain below)

List any additional health or other information you feel the staff should know about _____

_____

_____

**PERMISSION TO TRANSPORT**
I hereby give permission for my child to be transported to/from the event by a qualified driver:

Parent Signature: _____ Date: _____

**PUBLICITY RELEASE**
Photos of my son/daughter may be used in promotional materials:

Parent Signature: _____ Date: _____

**MEDICATIONS**

The following list includes over-the-counter medications available to treat minor afflictions as listed below. The dosage is determined according to the size/age of the child and specific directions on the package label. Please indicate whether or not these treatments may be given for each condition listed.

| Yes | No | Medication | Condition |
|---|---|---|---|
| | | Acetaminophen (Tylenol) | Relief of minor headache or fever |
| | | Chloraseptic Spray / Throat Lozenges | Sore throat |
| | | Sudafed | Relieve congestion |
| | | Antihistamine | Relieve congestion |
| | | Hydrogen Peroxide | Clean abrasions/cuts |
| | | Betadine / Phisohex | Clean abrasions/cuts |
| | | Neosporin | Treat abrasions/cuts |
| | | Sunscreen / Aloe | Prevent / treat sunburn |
| | | Caladryl / Hydrocortisone cream | Poison Ivy / Bites |
| | | Rhuligel/Calamine | Bee sting |

**OTHER MEDICATIONS WITH DOSAGE/SCHEDULE to be taken:**

_____

_____

*(All medication **must** be sent in original containers.)*

**PERMISSION TO GIVE MEDICINE**

I hereby give permission for my child as previously named to receive the above treatments as indicated with aid from designated staff:

Parent Signature: _____ Date: _____

**PARENT PERMISSION TO PARTICIPATE**

I hereby give permission for my child to participate in all activities. I will not hold the Trinity Lutheran Church responsible for conditions beyond their control. My child will follow the rules of and the directions of the program leaders.

Parent Signature: _____ Date: _____

**AUTHORIZATION FOR TREATMENT**

I hereby give permission to medical personnel selected by the staff to order x-rays, routine tests, and necessary emergency transportation for my son/daughter. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the staff to secure and administer treatment, including hospitalization, for my son/daughter as named above.

Parent Signature: _____ Date: _____

**PARTICIPANT AGREEMENT**

I understand and agree to abide by the rules and any restrictions placed on my activities:

Participant Signature: _____ Date: _____