

# First United Methodist Church 2011-2012 Health Form (Youth)

NAME OF CHILD:		Grade:	
HEALTH STATEMENT ... Please fill this out so that we might be more fully aware of your child's special needs and to facilitate any medical attention that might be required while on the event/trip.			
Parent or Guardian Name:		Home Phone # with area code:	
Full Mailing Address:			
Work Phone #(s) with area code and names:			
Cell Phone #(s) and names:			
Physician's Name:		Phone #:	
Dentist's Name:		Phone #:	
Restrictions on activities: Please specify	<input type="checkbox"/> None	<input type="checkbox"/> Sports	<input type="checkbox"/> Swimming
<input type="checkbox"/> Hiking			
Other (please specify):			
RESTRICTIONS ON DIET:			<input type="checkbox"/> Vegetarian
MEDICATIONS REQUIRED during event/trip. Give name, purpose, instructions for counselor or director:			
ARE THERE ANY MEDICATIONS YOUR CHILD SHOULD <u>NOT</u> BE GIVEN at event/trip? (ex. Aspirin, throat lozenge, laxatives) If yes, please specify. <input type="checkbox"/> yes <input type="checkbox"/> no			
ALLERGIES:	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa or other	<input type="checkbox"/> Tetanus shots
<input type="checkbox"/> Food (specify)	<input type="checkbox"/> Poison Ivy/Oak	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Bee or insect sting
<input type="checkbox"/> Other (specify)			
SUBJECT TO:	<input type="checkbox"/> Fainting	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Headaches
	<input type="checkbox"/> Sleepwalking	<input type="checkbox"/> Homesickness	<input type="checkbox"/> Cramps
	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Other (please specify):	
HAS HISTORY OF OR UNDER CARE FOR:	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis
	<input type="checkbox"/> Athlete's foot	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> ADHD	<input type="checkbox"/> ADD	<input type="checkbox"/> Other
Date of tetanus shot/booster:		Does child have his/her appendix?	
Does child have his/her tonsils?		Does child wear glasses?	
Does child wear contact lenses?		Does child wear hearing aid?	
Does child wear orthodontic braces?		Does child wear orthodontic retainer?	
Swimming ability: <input type="checkbox"/> Beginner <input type="checkbox"/> Intermediate <input type="checkbox"/> Advanced			
Any other information that would help staff better understand/relate to your child and make his/her experience more pleasant:			

Over, please. 

