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MEDICAL INFORMATION

YOUTH INFORMATION (*Please Print)*

Youth Full Name _____ Nickname _____

Home Address _____

Home Phone _____ DOB _____

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian Name(s): _____

List all parent/guardian contact phone numbers in best order to be reached: _____

_____

NON-PARENT/GUARDIAN EMERGENCY CONTACTS

Name: _____ Relation:_____

Phone(s):_____

PRIMARY CARE PHYSICIAN

Name:_____

Phone(s)_____ Fax: _____

Name of practice: _____

Date of last Tetanus shot (required)_____

INSURANCE INFORMATION

Medical Insurance Company: _____ Phone: _____

Policy/Group ID#: _____

Policy Holder's Name (please print): _____

Required: Attach a copy of medical insurance card here.

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MEDICATION: List all medications the youth will take during any youth ministry trips, retreats, or events. This includes any prescription, non-prescription medications, herbal supplements and vitamins. Any participant under the age of 18 is required to give **ALL MEDICATIONS to the adult youth leader in their original containers with complete dispensing instructions before the start of the event. Youth are not permitted to carry any prescription or non-prescription medication and will be sent home at the parent/guardian's expense if they do.**

Medication Name	Dose	Treatment for	Dispensing instructions
Example: Zyrtec	*5mg*	*Seasonal allergies*	*Take one pill daily in the morning with food*

_____

_____

_____

Over-the-Counter Medication Permission: Do you give permission for an adult youth leader to give your child/youth over-the-counter medications needed and as directed on the label, to treat medical conditions that do not appear to require a doctor or hospital visit such as a headache, stomachache, or allergic reaction (including, but not limited to aspirin, acetaminophen, ibuprofen, antacids, antihistamines, antibiotic ointments, etc.) while at a youth ministry event?

☐ **No**. Contact me before administering any over the counter medication to my child/youth. If I cannot be reached, I understand that my child will not receive any over-the-counter medications from an adult youth leader.

Parent signature_____

☐ **Yes.** I give permission for an adult youth leader to give my child/youth approved over-the-counter medications as directed on an as needed basis to treat non-emergency medical conditions. (If your child is allergic to any over-the-counter medications, please list those medications here: _____)

Parent Signature_____

MEDICAL CONDITIONS: Please answer in detail if applicable or write N/A. Attach additional pages if necessary.

1. Please list all known medical conditions (asthma, diabetes, epilepsy, etc.):

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2. List any allergies (drug/medicine, food, and/or environmental) and the severity and type of reaction:

3. Please explain any other pertinent information about the participant (i.e. physical, behavioral, or emotional) that would be important for the adult leaders to know.

I hereby represent that my child/youth is in good health, that I have identified all known medical conditions, and that I have adequately informed MUMC youth staff (in writing) of any special concerns. **I understand that trained medical personnel will not necessarily be present at all MUMC youth events, and I authorize MUMC youth staff and/or volunteers to call for medical care or to transport my child to a medical facility or hospital if, in the opinion of such staff/volunteer, my child needs medical attention. I further authorize appropriate personnel to render such medical treatment as is necessary for the health of my child, in their professional opinion.**

_____ x_____ _____
Name of youth participant Signature of youth participant Date

_____ x_____ _____
Name of parent/guardian Signature of parent/guardian Date