

**CHILD/YOUTH HEALTH AND MEDICAL INFORMATION FOR OFF-SITE ACTIVITIES**

This form is to be attached to the Parental Consent and Medical Authorization form.

**STUDENT INFORMATION**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
Gender  Male  Female Home Phone \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Emergency Contact (Name and Phone): \_\_\_\_\_

**HEALTH HISTORY**

(Check and give approximate dates)

Frequent Ear Infection \_\_\_\_\_ Hay Fever \_\_\_\_\_ Chicken Pox \_\_\_\_\_  
Heart defect/disease \_\_\_\_\_ Convulsions \_\_\_\_\_ Mumps \_\_\_\_\_  
Diabetes \_\_\_\_\_ Measles \_\_\_\_\_ Mononucleosis \_\_\_\_\_  
Hypertension \_\_\_\_\_ German Measles \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Please list all allergies: \_\_\_\_\_

What treatment (if any) is required for Asthma? \_\_\_\_\_

Operations or Serious Injuries: \_\_\_\_\_

Dietary Modifications: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Student's Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Student's Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Student's Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

**PRIVACY PRACTICES:** I understand that by signing the Christ Church United Methodist, Inc./School Parental Consent and Medical Authorization that a representative of the church/school will be in possession of my minor child's medical information. I further understand that in the event of an emergency, I am giving permission for Christ Church United Methodist, Inc.'s/School representative to provide the medical information contained on the Parental Consent and Medical Authorization form to any and all health care providers selected by Christ Church United Methodist, Inc./School representatives for the purpose of providing necessary and appropriate medical care to my minor child.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Notary Signature \_\_\_\_\_ Date \_\_\_\_\_

Notary Stamp