# YOUTH EVENT HEALTH FORM

Bring this completed form with you to the event or turn-in with your registration.

Youth will not be allowed to stay at the event without completing and filling out this form. Youth with special needs are encouraged to contact the event leadership before coming to the event.

Name: _____

D.O.B._____ Telephone #: _____

Permanent Address: _____

_____

Parent/Guardian – Emergency Information

Parent/Guardian's Name: _____

Address: _____

Home: _____ Office: _____

Cell: _____ Other: _____

Parent/Guardian's Name: _____

Address: _____

Home: _____ Office: _____

Cell: _____ Other: _____

Emergency Contact Person: _____

Relationship to Youth: _____

Home: _____ Office: _____

Cell: _____ Other: _____

Doctor: _____ Office: _____

Last Health Examination Date: _____ (must be within past 2 years)

This individual is physically fit to participate in the event: ☐ Yes ☐ No

Doctor's Signature: _____

(Must have Doctor's signature if your youth is taking any prescription medication on a regular basis)

Insured Name: _____

Insurance Company: _____ Policy #_____

Included with this form is a copy of the Insurance Card. ☐ Yes ☐ No

Check each area which applies so that we will be aware of your youth's needs.

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ( ) | ( ) | current tetanus protection | ( ) | ( ) | history of chronic infection | ( ) | ( ) | diabetes |
| ( ) | ( ) | heart condition | ( ) | ( ) | skin diseases | ( ) | ( ) | fainting |
| ( ) | ( ) | regular medications | ( ) | ( ) | food restrictions | ( ) | ( ) | hearing aid |
| ( ) | ( ) | bee sting allergies | ( ) | ( ) | asthma | ( ) | ( ) | ADD/ADHD |
| ( ) | ( ) | convulsions/seizures | ( ) | ( ) | nose bleeds | ( ) | ( ) | bed wetting |
| ( ) | ( ) | wears contact lenses | ( ) | ( ) | other significant allergies | ( ) | ( ) | sleep walking |
| ( ) | ( ) | menstruates (females only) | ( ) | ( ) | blood disorder (explain under chronic conditions) | | | |

Medications: List prescription, dosage and frequency. Medications must be clearly labeled and placed in a Ziploc bag with the individual's name on it.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Drug allergies or other chronic conditions: List other conditions that require ongoing attention.

1. _____
2. _____
3. _____

Physical Restrictions: List chronic conditions that restrict activity. i.e. heart, lung, arthritis, etc.

1. _____
2. _____
3. _____

Food Restrictions: List food allergies, restrictions because of prescriptions, etc.

1. _____
2. _____
3. _____

I give permission for staff to administer over-the-counter medications for items checked "Yes" below if deemed necessary. Dosages will be administered according to directions on the container unless a physician directs otherwise.

| Yes No | Yes No | Yes No |
|---|---|---|
| ( ) ( ) ear drops for swimmer's ear? | ( ) ( ) Cladryl lotion? | ( ) ( )Sudafed/pseudoephedrine |
| ( ) ( ) antacids for upset stomach? | ( ) ( ) Tylenol/acetaminophen? | ( ) ( ) Zyrtec/cetirizine |
| ( ) ( ) cough medicine/cough drops? | ( ) ( ) Benadryl/diphenhydramine? | ( ) ( ) throat lozenges |
| ( ) ( ) Medication for diarrhea? | ( ) ( ) Motrin/ibuprofen? | |

PARENT'S/GUARDIAN'S CONSENT FOR MEDICAL TREATMENT AND MEDICATIONS

I hereby give my permission for staff to provide routine health care; to administer medications; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide for or arrange necessary transportation for my son/daughter. I also give my permission to release information on this form for the purpose of assisting with medical treatment.

If I cannot be reached in an emergency, I hereby give my permission to the staff selected by the youth event leadership to secure and administer treatment, including hospitalization, for the person named above. This form may be photocopied for off-site event-related trips.

**Parent/Guardian Signature: _____ Date:_____**