



Immanuel Youth Health Information Form

Student Name _____ DOB _____

In case of an emergency, contact _____ (name)

_____ (phone number)

_____ (relationship to student)

Physician's Name _____ Phone _____

Students Health Insurance _____

Indicate if you child has any of the following:

- | | | | | | |
|----------------------------|--------------------------|-------------------|--------------------------|------------------------------------|--------------------------|
| ADD/ADHD | <input type="checkbox"/> | Cystic Fibrosis | <input type="checkbox"/> | Migraine Headaches | <input type="checkbox"/> |
| Allergy: Food | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | Muscular/Orthopedic Disorder | <input type="checkbox"/> |
| Allergy: Insect Bite/Sting | <input type="checkbox"/> | Eating Disorder | <input type="checkbox"/> | Psychiatric/Psychological Disorder | <input type="checkbox"/> |
| Allergy: Other | <input type="checkbox"/> | Epilepsy/Seizures | <input type="checkbox"/> | Special Needs | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Hearing Condition | <input type="checkbox"/> | Vision (needs corrective lenses) | <input type="checkbox"/> |
| Blood Disorder | <input type="checkbox"/> | Heart Condition | <input type="checkbox"/> | Chicken Pox (when_____) | <input type="checkbox"/> |
| Cerebral Palsy | <input type="checkbox"/> | Kidney Disorder | <input type="checkbox"/> | | |

If you checked any of the boxes above, or if your child has a medical condition not listed, please explain (including specific food, medication or other serious allergies) _____

Past history of injuries/illnesses/hospitalizations/surgeries: _____

Please list all medications your child is currently taking:

Medication Name _____ Dose _____ Reason _____

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I, the undersigned, do hereby authorize Immanuel Lutheran staff to contact alternative adults and physicians listed. I authorize the Youth Director, or trained personnel, to render treatment deemed necessary in case of an emergency. I authorize medical information to be shared with appropriate personnel. I will not hold Immanuel Lutheran Church financially responsible for the emergency care and/or transportation of said child.

Signature of Parent/Guardian

Date