LAKE REGION CONFERENCE

Youth Ministries Department

Health and Medical Record Form – Page 1

Youth Identification Information			
Name			
Age		Gender (Circle One)	
Birth Date		Male	Female
Home Address			
City		State / Zip	
Home Phone #		Mobile Phone #	
Email Address			
Church		Religion	

Health History
Please check all boxes that apply

	Asthma		Bedwetting		Epilepsy		Hay Fever
	Rheumatic Fever		Kidney Disease		Sinus Trouble		Constipation
	Heart Trouble		Ear Aches		Ear Infection		Diarrhea
	Glasses		Ear Tubes		Stomach Aches		Contact Lenses
	Fainting Spells		Diabetes		Menstrual Problems		Tuberculosis
	Sleep Walking		Other _____		Other _____		Other _____

Allergies or Allergic Reactions
(Check if YES and tell what happens)

	Penicillin	
	Bee Sting	
	Food	
	Poison Oak/ Poison Ivy	
	Other Medication (list)	
	Other – List	
	Other – List	
	Other – List	

Please list all Serious illnesses or Operations

Operation or Illness		Date		Hospitalized? Y / N

Medication Name		Number of Times in Day		Reason for Taking

Diet Needs

	Regular		Diabetic		Low Salt		Low Fat/ Cholesterol
	Other - Special Instructions						

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Health and Medical Record Form – Page 2

Immunization History

Required immunizations must be determined locally. This is a record of dates of basic immunizations and most recent booster doses.

Medication Name	Date	Medication Name	Date	Medication Name	Date
DTP Series		Tuberculin Test		Polio OOPV (Sabin)	
Mumps Vaccine		Measles Vaccine		Chicken Pox	
German Measles		Tetanus Booster		Other Booster	

Does your child meet current state law for school attendance? (Circle One)		Do you have any medical exemptions? (Circle One)		Do you have any religious exemptions? (Circle One)	
Yes	No	Yes	No	Yes	No
If no, please explain:		If yes, please explain:		If yes, please explain:	

Physical Activity

Any restriction of activity for medical reason? Please explain	
Any other type of health concerns which might be pertinent?	

Who to Inform – In Case of Accident and/or Illness

Parent / Guardian / Spouse		Home Phone #	
Email Address		Mobile Phone #	

If above person(s) are not available in emergency – please notify

Name		Relationship	
Home Address		Home Phone #	
Email Address		Mobile Phone #	
Name		Relationship	
Home Address		Home Phone #	
Email Address		Mobile Phone #	

Doctor to Consult in Case of Emergency

Doctor's Name		Phone #	
Address			
City		State / Zip	

Do You Have…?

Medical Insurance?		Insurance Number	Type of Coverage
Yes	No		

Parent / Guardian's Authorization Required for Those Under 18 Years of Age

The Information Above is Correct to the Best of My Knowledge

Parent/ Guardian Signature	Date

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. In the event I cannot be reached in an emergency, I hereby give permission to the physicians selected by the adult leader to hospitalize, secure proper anesthesia, or to order injection or surgery for my child. A Photostat copy of this shall be as valid as the original.

Parent/ Guardian Signature	Date

Comments and/or Suggestions from Parents