Trinity Youth Conference 2017 Health Information Form

Information obtained in this form will be kept confidential.

SECTION I—BASIC CONTACT INFORMATION

Participant Name: _____ Date of Birth: _____

Complete Address: _____

Parent/Guardian Name (for those under 18):_____ Relationship: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Secondary Emergency Contact: Name: _____ Relationship: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Primary Care Physician: _____ Phone: _____

Office Address: _____

Dentist: _____ Phone: _____

Office Address: _____

SECTION II—HEALTH HISTORY:

Insurance Information: ***Please provide a copy of the front and back of your insurance card and prescription card.***

Name of Insurance Company: _____

Group #: _____

Name of Covered Individual: _____ Card #: _____

Covered Individual's Social Security #: _____

Insurance Billing Address: _____

Insurance Phone #: _____

Name of Insured: _____ Insured's Social Security #: _____

Insured's Employer: _____ Insured Employer's Phone #: _____

Insured Employer's Address: _____

Name of Prescription Card: _____ Prescription Card #: _____

Pharmacy of Choice: _____

HEALTH HISTORY: Please give approximate date or pertinent information.

___ Asthma/Breathing Difficulty

___ Diabetes (Type ___ Onset _____)

___ Heart Defect/Disease/Heart Irregularity

___ Tonsillitis

___ Bleeding/Clotting Disorders

___ Fainting

___ Convulsions

___ Epilepsy (onset_____)

___ Joint or Bone injury/pain

___ Frequent Ear Infections

___ Other: Please explain_____

_____

___ Strep Throat

___ Mononucleosis

Diseases:

___ Rheumatic Fever Date: _____

___ Chicken Pox Date: _____

___ Measles Date: _____

___German Measles Date: _____

___ Mumps Date: _____

___ Other: Please explain and date: _____

_____

_____

******CONTINUED ON REVERSE******

_____ _____

Last Name, First Name Date of Birth

ALLERGIES: Please list reaction and your choice of treatment.

___ Hay Fever Treatment: _____ ___ Poison Ivy Treatment: _____

___ Insect Stings Treatment: _____ ___ Penicillin Treatment: _____

___ Peanuts Treatment: _____

___ Other Foods: _____

___ Other Drugs: _____

Please describe symptoms and treatments: _____

_____

Is the participant currently under a doctor's care for any condition or illness?

___ No ___Yes (please explain condition and treatment): _____

_____

Does the participant have any physical condition that could/would prohibit him/her from participating in any sport or activity at the camp? ___ No ___ Yes (please specify): _____

Has the participant had an operation or serious injury in the last two years? ___ No ___Yes (please explain):

_____

Most recent tetanus (month/year): _____ Most recent physical: (month/year): _____

Please notify the camp if the participant has been exposed to any communicable disease during the three weeks prior to camp attendance, or if the participant has been seen by a physician for any reason during this period.

SECTION III—MEDICATIONS: For the safety of all participants, **any prescription medications (except inhalers) must be locked in the nurse's medication cabinet for the week.** The participant will be responsible for taking their own medication at the appropriate times, as dispensed by the nurse.

MEDICATION LIST: Please provide all prescription medications. Please refrain from supplying your own over-the-counter medications, these will be provided by the camp RN. **Attach an additional sheet if needed.**

Please note if any medications are new to the participant in the last month.

Name of medication: _____ Reason for taking: _____

Dosage: _____ Time that the medication is taken: _____

Specific directions of administration (e.g., on an empty stomach/with water): _____

Storage Requirements: _____ Side effects: _____

Are there any over-the-counter non-prescription medications or ointments that SHOULD NOT be given to your child (i.e. bug spray, Tylenol, Sudafed, etc.): _____

If the participant will be under the age of 18 during Trinity Youth Conference 2017, a parent/guardian must complete, sign, and date the following:

I _____, hereby authorize Trinity Youth Conference staff to proceed with medical
NAME OF PARENT/GUARDIAN
treatment for my son/daughter, _____, in the event of a medical emergency and further
NAME OF PARTICIPANT
acknowledge that I am solely responsible for all medical expenses should my child need treatment in the event of a medical emergency.

_____ _____

Signature of Parent/Guardian Date