

**NORTHERN HILLS UNITED METHODIST CHURCH 2022**

THIS FORM MAY BE PHOTOCOPIED WHEN COMPLETED. PRINT CLEARLY. USE BLACK INK.

**NAME** \_\_\_\_\_  
Last First Middle Home phone

**ADDRESS** \_\_\_\_\_ **CITY** \_\_\_\_\_ **ZIP** \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth Grade School **Youth Cell Phone** \_\_\_\_\_

\_\_\_\_\_  
Youth's Doctor /Clinic Doctor's Phone

**Date of Last: Health Exam** \_\_\_\_\_ T.B. test

**SHOT RECORD:** \_\_\_\_\_ Hepatitis A \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Tetanus Shot

\_\_\_\_\_  
Father's Name Work Phone Cell Phone

\_\_\_\_\_  
Mother's Name Work Phone Cell Phone

\_\_\_\_\_  
Alternate Emergency Contact Name Day Phone Evening Phone Relationship

**HEALTH HISTORY:** (CHECK THOSE THAT APPLY)

**DRUG ALLERGIES:** \_\_\_\_\_

**OTHER ALLERGIES:** \_\_\_ Animals \_\_\_ Food \_\_\_ Insect stings \_\_\_ Plants \_\_\_ Pollen \_\_\_ Other

*If any checked please explain:* \_\_\_\_\_

**CHRONIC OR RECURRING ILLNESS:**

\_\_\_ Ear infections \_\_\_ Contact lens wearer \_\_\_ Heart defect/disease \_\_\_ Seizures \_\_\_ Bleeding disorder

\_\_\_ Asthma \_\_\_ Diabetes \_\_\_ Other (specify) \_\_\_\_\_

**SURGERIES, INJURIES OR OTHER HEALTH ISSUES:** \_\_\_\_\_

**IN THE LAST YEAR:** (ANSWER YES OR NO)

Have you been out of the USA in the last year? \_\_\_\_\_

Complicating medical problems/operations? \_\_\_\_\_ Serious injury/illness requiring medical care? \_\_\_\_\_

*Please explain:* \_\_\_\_\_

**SPECIFIC INSTRUCTIONS CONCERNING MY CHILD'S CARE:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HOSPITAL INSURANCE INFORMATION:** \* Please attach photocopy of insurance card

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Name of Carrier	Policy Number	Group Number
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Insured's Name

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Company Name (if insured through employer)

**FAMILY MEMBER (S) WHO MAY BE CONTACTED IN CASE OF EMERGENCY TO AUTHORIZE TREATMENTS:**

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Name	Day Phone	Evening Phone	Relationship
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Name	Day Phone	Evening Phone	Relationship
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**MEDICAL TREATMENT AUTHORIZATION**

I (we) understand that in the event the child named above is injured while in the care of Northern Hills United Methodist Church and requires the attention of a doctor, the Director of Student Ministries, and/or representatives of Northern Hills United Methodist Church will make every effort to contact us. If I (we) cannot be reached by telephone at one of the numbers listed above, or if because of an emergency, there is not time or opportunity to make a telephone call, I (we) hereby authorize the Director of Student Ministries, and/or representatives of Northern Hills United Methodist Church to give consent on my (our) behalf for emergency medical treatment. In the event that it becomes necessary for a representative of Northern Hills United Methodist Church to give consent on our behalf they are authorized:

1. To have access to any and all medical and related information and records.
2. To disclose medical and related information to others.
3. To employ and discharge medical and related personnel.
4. To consent or refuse consent to medical care and emergency medical procedures.
5. To provide appropriate relief from pain.
6. To arrange for care and lodging in a hospital.
7. To grant releases to health care professionals or institutions to assure that the wishes of the parent/guardian are fulfilled.
8. To take immediate physical custody and possession of the child that is the subject of this authorization in the absence of the ability of the parent/guardian to do so, and to provide for the care and physical custody thereof during such absence.

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Parent Signature

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Date