

Orcutt Presbyterian Church  
Youth Personal Health Record and Medical Information

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**Update annually for all participants.** Activity: This form is for youth participating in church activities such as day or overnight camps, hikes, or other off-site programs with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

**PERSONAL HEALTH AND MEDICAL HISTORY**

(To be filled out annually by parent, guardian or adult participant. Please use ink.)

**IDENTIFICATION**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_

Name of parent or guardian \_\_\_\_\_ Telephone \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If person named above is not available in the event of an emergency, notify

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name of personal physician \_\_\_\_\_ Telephone \_\_\_\_\_

Personal health/accident insurance carrier (PLEASE ATTACH COPY OF INSURANCE CARD):

Policy No. \_\_\_\_\_

Other Information needed to use card or required by hospital (e.g. SSN, Driver's License):

\_\_\_\_\_

**PERMISSION TO TREAT**

**In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).**

In signing this form the parent agrees to release this information including information about your child's health history, medications, immunizations and any other information on this form to the Youth Director and any members of the adult ministry team attending youth events.

1. Signature of parent/guardian or adult \_\_\_\_\_ Date \_\_\_\_\_

Form can be reviewed and update for up to 4 years:

The undersigned has reviewed the information presented on this form, and confirms that all information is current and accurate at this time.

2. Signature of parent/guardian or adult \_\_\_\_\_ Date \_\_\_\_\_

3. Signature of parent/guardian or adult \_\_\_\_\_ Date \_\_\_\_\_

4. Signature of parent/guardian or adult \_\_\_\_\_ Date \_\_\_\_\_

# Orcutt Presbyterian Church Youth Personal Health Record and Medical Information

## PERSONAL HEALTH AND MEDICAL HISTORY (cont.)

(To be filled out annually by parent, guardian or adult participant. Please use ink.)

Check all items that apply, **past or present**, to your health history. Explain any "Yes" answers.

**ALLERGIES:** Food, medicines, insects, plants    Yes     No     Explain: \_\_\_\_\_

<b>GENERAL INFORMATION:</b>	Yes	No	Yes	No	Yes	No		
ADHD (Attention-Deficit)								
Hyperactivity Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>

Explain: \_\_\_\_\_

Please list ALL medications taken in the 30 days **prior** to arrival at the activity where this form is to be used:

\_\_\_\_\_

List any medications to be taken at camp/event: \_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation in swimming, hiking long distances, or playing strenuous physical games: \_\_\_\_\_

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: \_\_\_\_\_

**Immunizations:** (Give date of last inoculation.)

Tetanus toxoid _____	Measles _____	Polio _____
Diphtheria _____	Mumps _____	_____
Pertussis _____	Rubella _____	_____

**Limitations**

Activity restrictions \_\_\_\_\_

Diet restrictions \_\_\_\_\_

Doctor \_\_\_\_\_ Date \_\_\_\_\_  
Licensed health-care practitioner\*

Address \_\_\_\_\_ Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_