



ST.MARK LUTHERAN CHURCH HEALTH FORM

Please complete the following health form and return it to St. Mark Lutheran Church. For Youth under 18 years of age, the enclosed health form must be completed. **A physical is required only if there are any health problems or activity limitations noted in the health history on the health form.** A photocopy of a completed physical form signed by a physician and dated within the last twelve months is acceptable. **If there are no health problems or activity limitations listed, a physical is not needed.** Parents or legal guardians must complete the following form:

NAME OF ATTENDEE: Last _____ First _____ MI _____

DATE OF BIRTH: _____ AGE: _____

Gender: Male: _____ Female: _____ GRADE COMPLETED: _____

PARENT/GUARDIAN: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: Home: () _____ Work: () _____ Cell: () _____

IF NOT AVAILABLE, IN EMERGENCY CALL OR NOTIFY:

NAME: _____ RELATIONSHIP: _____

PHONE: Home: () _____ Work: () _____ Cell: () _____

IN THE EVENT OF AN ACCIDENT OR INJURY REQUIRING MEDICAL ATTENTION, YOUR PERSONAL INSURANCE WILL BE CONSIDERED THE PRIMARY CARRIER.

INSURANCE COMPANY NAME and ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

INSURED: _____ POLICY # _____

EMPLOYER NAME: _____ GROUP # _____

IN THE EVENT THE ABOVE NAMED YOUTH PARTICIPANT NEEDS TO SEE A DOCTOR FOR AN ILLNESS WHILE AT THE RETREAT, THE BILL SHOULD BE SENT DIRECTLY:

Check one: TO THE PARENTS

TO THE PARENTS' HEALTH INSURANCE COMPANY



HEALTH HISTORY: (Check - give approximate dates)

- Diabetes _____
- Convulsions _____
- Rheumatic Fever _____
- Ear Infections _____
- Chicken Pox _____
- Measles _____
- Asthma _____
- Allergies: _____
- Hay Fever _____
- Penicillin _____
- Poison Ivy _____
- Insect Stings _____
- Food _____
- Other Drugs _____

OPERATIONS OR SERIOUS INJURIES (dates): _____

CHRONIC OR RECURRING ILLNESS: _____

CURRENT MEDICATIONS: _____

IMMUNIZATION HISTORY:

Please note the date of the shots or most recent booster doses. If dates are unknown, please indicate if the person has received the immunization.

DPT SERIES: _____ BOOSTER: _____

POLIO OPV: _____ BOOSTER: _____

MEASLES: _____ SMALLPOX: _____

TETANUS BOOSTER: _____ TYPHOID: _____

PARENTS' AUTHORIZATION:

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted by me and/or the examining physician.

In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by St. Mark Lutheran Church to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above. I also consent to the use of any photography and/or video of my child in current or future St. Mark Lutheran Church publications.

Signature of Parent or Guardian

Date

OTHER COMMENTS FROM PARENTS:

