ST. DAVID'S
EPISCOPAL CHURCH

Health and Medical Form

June 2013 – July 2014

Name of Participant _____ **Date of Birth** _____

Grade in Fall 2012 _____

***Primary Contact*:**
Parent/Guardian Name _____**Home Phone** _____

Cell Phone _____**Work Phone** _____

***Secondary Contact*:**
Parent/Guardian Name _____ **Home Phone** _____

Cell Phone _____**Work Phone** _____

Medical Insurance Company _____ **Policy #** _____

Policy Holder Name _____

Participant's Physician _____**Phone** _____

Family Dentist _____ **Phone** _____

Emergency Contacts (in the event parent/guardian cannot be reached)

_____ **Phone** _____

MEDICATIONS: Please list all current medications, dosages and times taken:

_____

_____

Any special instructions? _____

_____

□ I understand that any medications brought to the program should be clearly labeled and in their original container. I also understand that all prescription medication will remain in the possession of St. David's Episcopal Church personnel and/or the parish adult leader and be dispensed as prescribed.

□ I grant permission for non-prescription medication (such as ibuprofen, Tylenol, throat lozenges, cough syrup) to be given to my child, if deemed advisable.

If there are any non-prescription medications you do <u>not</u> want administered to your child, please list them:

_____

ALLERGIES: Please identify any allergies (food, medication, insects): _____

_____

Does your child carry an Epi-Pen? Y/N _____

Please identify any special dietary modifications/prohibitions:_____

_____

OPERATIONS OR SERIOUS INJURIES: (Within the past 18 months)

_____

MEDICAL EMERGENCY:

Please include any additional remarks to better assist in an emergency situation (health history, etc.): _____

_____

In case of medical emergency, I understand that a reasonable effort will be made to contact the parents or guardians of participants in St. David's-sponsored programs. In the event that none of the above contacts can be reached, I hereby give permission to the physician selected by St. David's Episcopal Church personnel and/or parish adult leader to hospitalize, secure proper treatment for, and to order x-ray, injection, anesthesia or surgery for my child. This authorization is given in advance of any specific diagnosis, treatment or hospital care required, but is given to provide authority and power to render care which is deemed advisable in the best judgment of the physician.

STATEMENT OF HEALTH: I hereby warrant that, to the best of my knowledge, my child is in good health and able to participate in all St. David's-sponsored programs. (Please submit a statement indicating limitations and/or conditions of which we should be aware).

Parent/Guardian _____

Date _____

Please sign