FAITH KIDS SUMMER CAMP

Personal Medical History Form

(Revised Mar. 2018)

The purpose of this form is two-fold:

1) *To ensure that in the event that the Faith Kids' Summer Camp Leadership Team needs to take your son or daughter to the emergency room they will be able to provide accurate health information about your son or daughter to medical personnel.*
2) *To ensure that our Camp Nurse knows what medications your son or daughter can and cannot take.*

Please print clearly in ink

Student's Name: _____

Address: _____

Home phone: _____ Parent's Cell Phone: _____

Student's Date of Birth: _____

Name of Parent or Guardian: _____

Parent / Guardian's Employer: _____

Parent / Guardian Work Phone No.: _____

Health Insurance Carrier: _____

Name of Subscriber: _____

Policy No.: _____ Group No: _____

Name of Person to be Contacted if Parent / Guardian cannot be reached:

_____

Phone No.: _____

Relationship to Child: _____

Student's Age: _____ Height: _____ Weight: _____

Known allergies: _____

Is your child currently taking any medications? Yes No

If so, please list the name of the medicine and the dosage:

_____

If your child is under the care of a physician, please list the name and phone number:

_____

Has you child ever had any of the following ailments? (Please circle those which apply)

ASTHMA
HAY FEVER
BRONCHITIS
CHRONIC SINUS INFECTIONS
CHRONIC EAR INFECTIONS
STREP THROAT
KIDNEY INFECTIONS
ULCERS
FAINTING SPELLS
HEPATITIS
MOTION SICKNESS
HIGH BLOOD PRESSURE
HEART DISEASE
DIABETES
LOW BLOOD SUGAR
ANEMIA
MIGRAINE HEADACHES
INSOMNIA
SLEEPWALKING
MONONUCLEOSIS
FREE-BLEEDING

Has your child ever had an allergic reaction to medicines, foods, animals, or insect bites?

If yes, please explain: _____

Has any member of your child's immediate family (birth father, birth mother, sister, brother) ever had any of the following?: (Please circle those which apply)

ALLERGIC REACTION TO MEDICINES
ALLERGIC REACTION TO FOODS
ALLERGIC REACTION TO ANIMALS
ALLERGIC REACTION TO INSECT BITES

(If yes, please explain: _____)

DIABETES HIGH BLOOD PRESSURE
HEART ATTACK FREE-BLEEDING

List other serious medical problems occurring in the immediate family:

_____

Has your child ever had surgery? Yes No

If yes, please list: _____

Approximate date of surgery: _____

Has your child ever had a broken bone? Yes No

If yes, please list: _____

Does your child have any metal implants in his/her body? Yes No

If yes, please list: _____

Does your child wear contact lenses? Yes No Dentures? Yes No

Any type of bridgework, retainers, etc.? _____

DATE OF LAST TETANUS SHOT? _____

My child has my permission to ask for and take (*with the supervision of a youth leader*) any of the following over-the-counter medications indicated below:
(Please circle **yes or no** by each item listed)

Yes	No	Tylenol
Yes	No	Anti-inflammatory / Anti-cramp (Advil, Aleve)
Yes	No	Pepto Bismol
Yes	No	Cough Syrup / Coughdrops
Yes	No	Antacids / Anti-gas (Maalox / Mylanta)
Yes	No	Motion Sickness (Dramamine)
Yes	No	Antihistamine (Benadryl, Chlortrimeton, Tavist, Claritin)
Yes	No	Decongestant (Sudafed, Claritin D)
Yes	No	Anti-diarrhea (Imodium A-D)
Yes	No	Laxative (Senokot)

(Note: Generic Brands may be used)

Additional over-the-counter medicines your child may need must be turned into the Leadership Team at check-in. Please leave them in their original container and label each with your child's name.

I understand that all medicines are to be turned into the Faith Church Leadership Team upon arrival at the Church. **All prescription medicines should be left in their original container with the prescription label on it.** The taking of **ALL** medicines will be supervised by a Youth Leader (the only exception to this rule will be for asthma inhalers or nitroglycerin tablets). This policy is for your child's safety and the safety of other children in the group.

Signature of Parent / Legal Guardian: _____

Printed Name of Parent / Guardian: _____

Date: _____