

Student Information: (Please Print)

Student's Full Name: _____

Date of Birth: _____ Gender: _____

Street/Mailing Address: _____

City/State/Zip: _____

Parent(s)/Guardian to be contacted in case of injury/illness: _____

Please list all numbers where parent(s)/guardian can be reached: Home: _____

Cell Phone: _____ Work: _____ Other: _____

In the event that the parent or guardian cannot be reached please list another contact:

Name of Contact: _____ Relationship to Student: _____

Phone numbers of other contact: _____

Parent/Guardian Authorization for Healthcare:

In case of an emergency, illness or accident, parents or guardians will be contacted at the earliest possible moment. However, as contacts cannot always be made immediately, we need permission for emergency medical care. In the event that said student suffers any illness or accident requiring emergency treatment, hospitalization, medication, or surgery, I hereby authorize any necessary treatment, hospitalization, medication, or surgery recommended by a licensed physician and approved by the person(s) in charge of St. Andrew's Youth Ministries.

Signature of Parent/Guardian: _____ Date: _____

Insurance Information:

Primary Insurance Company: _____

Policy Number: _____ Code: _____

Employer/Employee Name: _____

Secondary Insurance Company: _____

Policy Number: _____ Code: _____

Employer/Employee Name: _____

STUDENT INFORMATION

Known Allergies/Allergic Reactions: _____

Medications Presently Taking and Schedule: _____

Medications Student is Allergic to: _____

Below are some medications which leaders might provide to your student. Please mark through any you would not like your child to take.
Acetaminophen (Tylenol), Ibuprofen (Advil, Motrin), Sudafed, Robitussin, Benadryl, Ex-Lax, Bismuth Kaopectate, Pepto-Bismol.

Please Indicate the Following

Has/does the student:

- 1. Ever been hospitalized? Yes No
- 2. Had fainting or dizziness? Yes No
- 3. Ever had surgery? Yes No
- 4. Passed out/had chest pain during exercise? Yes No
- 5. Recurrent/chronic illnesses?..... Yes No
- 6. Has history of concussions?..... Yes No
- 7. Had a recent infectious disease? Yes No
- 8. If female, have problems with menstruation?..... Yes No
- 9. Had a recent injury? Yes No
- 10. Have problems with falling asleep? Yes No
- 11. Had asthma/wheezing/shortness of breath?..... Yes No
- 12. Ever had back/joint problems?..... Yes No
- 13. Have diabetes? Yes No
- 15. Had seizures? Yes No
- 16. Have problems with diarrhea/constipation?..... Yes No
- 17. Had chronic headaches? Yes No
- 18. Have any skin problems?..... Yes No
- 20. Wear glasses, contacts, or protective eyewear? Yes No
- 21. Mental illness or other psycho/social issues?... Yes No
- 22. History of illegal drug use?..... Yes No

If you need to elaborate on any of the above or if there are any other medical concerns that the leaders should know, please indicate below.
