



East Lake United Methodist Church
2010 HEALTH FORM AND MEDICAL RELEASE

Personal Information

Name _____ Birth Date _____ Age _____ Sex _____
Last First Initial

Parent or Guardian _____ Phone () _____

Home Address _____
Number and Street City State Zip

Business Address _____
Number and Street City State Zip

Second Parent or Guardian or Emergency Contact _____

Home Address _____
Number and Street City State Zip

Business Address _____
Number and Street City State Zip

If not available in an Emergency, notify:

Name _____ Phone () _____

Address _____
Number and Street City State Zip

Health Information

Frequent Ear Infection _____	Mononucleosis _____
Hay Fever _____	Heart Defect Disease _____
Ivy Poisoning _____	Convulsions _____
Chicken Pox _____	Bee/Insect Stings _____
Diabetes _____	Measles _____
Penicillin _____	Bleeding/Clotting _____
German Measles _____	Other Drugs _____
Disorders _____	Mumps _____
Asthma _____	Hypertension _____

What treatment is required for Asthma _____

Operations or serious injuries (dates) _____

Dietary Modifications _____

Current Medications (send with instructions) _____

Food Allergies _____

Drug Allergies _____

Other Allergies _____

What treatment is required for allergy? _____

Any other health issues that we should be aware of? _____

Date of Last Tetanus Shot (required) _____

May adults in charge administer (circle) Aspirin – Y/N Tylenol – Y/N Advil – Y/N
Excedrin – Y/N Aleve – Y/N

Name of Family Physician _____

Address _____

Number and Street

City

State

Zip

Insurance Coverage

Insurance Company _____ Phone () _____

Policy Number: _____ Group # _____

I hereby give permission to the Physician selected by the adult in charge of the East Lake United Methodist Church/Children's Activity to order X-Rays, routine tests and treatment for the health of my child, and in the event that I can not be reached in an emergency, I hereby give permission to the Physician selected by the adult in charge to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for my child as named above.

Parent or Guardian Signature _____ Date _____

STATE OF FLORIDA: COUNTY OF PINELLAS

The foregoing instrument was acknowledged before me this _____ day of _____, year 20_____. By _____, who is personally known to me or who has produced _____ as identification and who did not take an oath.

Signature of Notary

Name of Notary, printed or stamped

Notary Public

(Serial Number, if any)