



East Lake United Methodist Church
2012-2013 HEALTH FORM AND MEDICAL RELEASE

Personal Information—PLEASE PRINT CLEARLY

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

Home Address _____
Number and Street City State Zip

Parent or Guardian _____ Home Phone () _____

Work Phone () _____ Cell Phone () _____

Second Parent or Guardian or Emergency Contact _____

Home Address _____
Number and Street City State Zip

Work Phone () _____ Cell Phone () _____

If not available in an Emergency, notify:

Name _____ Relationship _____

Home Phone () _____ Work Phone () _____

Cell Phone () _____

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 Acetaminophen – Y/N Ibuprofen – Y/N
Antacid – Y/N Antibiotic Ointment – Y/N Benadryl – Y/N Cortisone Cream – Y/N Midol – Y/N

Name of Family Physician _____

Address _____

Number and Street _____ City _____ State _____ Zip _____
Phone number _____

Name of Dentist _____

Phone Number _____

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 or Youth 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)