St. Paul's United Methodist Church
398 N. Locust Street, N. Spruce & Oak Streets
Elizabethtown, PA 17022 717-367-1889

MEDICAL EMERGENCY FORM

TO BE COMPLETED AND SIGNED BY A PARENT OR GUARDIAN. PLEASE PRINT OR TYPE ALL ENTRIES.

Participant's Name ______________________ _____ ______________________________ Nickname _________________
(First) (M.I.) (Last)

Date of Birth _________________ Age _________ Sex: M F Current Grade ______ Height _________ Weight _________

Parent's Email Address ___________________________________ Church Affiliation ___________________________________

Student's Email Address___________________________________ Student's Cell Phone______________________Unlimited Text? Y/N

Street Address/Town/Zip Code ____

Name of Parents/Guardians ____

Street Address/Town/Zip Code of Parents/Guardians ____

Phone Numbers of Parents/Guardians at: Home ( ) _________ - _________ Work ( ) _________ - _________

IN CASE OF AN EMERGENCY, Please Notify: ***(Indicate by number of order desired – 1, 2, 3)***
( ) Parent/Guardian (See Above)

( ) ___________________________ Relationship to Participant _____________________ Phone # ( ) _________ - _________

( ) ___________________________ Relationship to Participant _____________________ Phone # ( ) _________ - _________

Physician's Name ____ Phone # ( ) _________ - _________

Family Medical/Hospital Insurance Carrier ____ Policy/Group # ___________________

Parents/Guardian's Insurance Group Name ____ Policy Holder's ID # _________________

Information is required since each participant is covered by limited accident and medical insurance---in excess of parent's own insurance: CHURCH'S POLICY IS A SECONDARY POLICY. Pennsylvania State law prohibits duplicate payments.

PART II: ILLNESSES AND INJURIES *(Check All Those That Apply)*

_____ AIDS/Arc	_____ Convulsions	_____ Epilepsy	_____ Lice	_____ Tuberculosis
_____ Asthma	_____ Diabetes	_____ Frequent Sore Throat	_____ Rheumatic Fever	_____ Upper Respiratory Infection
_____ Athlete's Foot	_____ Ear Infections	_____ Heart Disease	_____ Tonsillitis	_____ Other (Specify) _____________________

Date of Participant's Last Health Exam ____________________ Were any complicating medical problems noted? ______________________________

Is participant currently under a physician's care for a medical problem? ____

Since participant's last health exam, has he/she had:

_____ A serious injury requiring medical attention? Date: _________________ What ? ____

_____ A surgical operation or fracture? Date: _________________ What? ____

_____ Medication prescribed by a physician to be taken on a regular basis? Date: _________________ What? ____

_____ A diagnosed infectious disease? Date: _________________ What? ____

_____ A physician's restrictions from participating in any school physical education activity? Date: _________________ What? ____

NOTE: a written statement from your physician granting your child permission to participate in strenuous activity such as water sports, horseback riding, hiking or non contact sports is required if you indicated "yes" to any of the above questions.

(CONTINUED ON BACK)

PART III: IMMUNIZATIONS *(These dates MUST be completed.)*

DPT or TD: Date of Last Booster ____________________

Tuberculin Test: Type ________________________________ Date Given _______________ Results (Circle One): Positive Negative

PART IV: ALLERGIES *(Check All Those That Apply.)*

_____ Animals _____ Medicines/Drugs _____ Foods _____ Plants (Poison Ivy, Oak, etc.)
_____ Hay Fever _____ Pollens _____ Insect Stings _____ Other (Specify) ____________________

Please explain any allergies checked above and list treatment if any is necessary: ____
____

PART V: OTHER HEALTH CONDITIONS *(Check All Those That Apply.)*

_____ Bed Wetting _____ Fainting _____ Sleepwalking
_____ Constipation _____ Hearing Impairment _____ Stomach Upsets (Chronic)
_____ Ear Tubes – How Protected? _____ Menstrual Cramps _____ Wears Contact Lenses or Glasses
_____ Emotional Problems _____ Nosebleeds _____ Special Dietary Regiment (Please Contact Church)

Please indicate any information useful to the Church in relation to any of the above health conditions. Also indicate any activities which should be encouraged or restricted. ____
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PART VI: PARTICIPANT'S MEDICATION(S)

ALL medications are to be turned over to the Trip Supervisor at time of departure, along with a completed AUTHORIZATION FOR MEDICATION ADMINISTRATION form for EACH medication given to the Trip Supervisor. The Trip Supervisor will then insure that the medication(s) are administered in accordance with physician's instructions. For these purposes, "medication(s)" are broadly defined to include both non-prescription medication(s), home remedies and vitamins. We ask your fullest cooperation in this matter so that the participant's health and well-being may be properly safeguarded.

PART VII: CERTIFICATION & AUTHORIZATION

I certify that the information provided on this Health History Form is, to the best of my knowledge, complete and accurate. I know of no reason(s), other than the information indicated on this form, why my son/daughter should not participate in prescribed activities.

My son/daughter, ____________________ _____ ________________________ has my permission to participate in
(First Name) (M.I) (Last Name)
the activities associated with trips planned by Saint Paul's United Methodist Church, 398 N. Locust Street, N. Spruce & Oak Streets, Elizabethtown, PA. Further, in the event of an emergency, the Trip Supervisor or his/her designated representative for Saint Paul's United Methodist Church of Elizabethtown, PA, is authorized to act in my behalf in securing medical treatment for my child as named above.

______________________________________ ______________________________________
(Signature of Parent or Legal Guardian) (Date)