

SOUTHWEST CONFERENCE UCC HEALTH FORM

A completed and signed health form must be on file for **ALL YOUTH** and **STAFF**. One health form is sufficient for Southwest Conference youth events during the entire school year and following summer (**Sept. 2007—Aug. 2008**), provided there are no significant changes in health status. This form is to be completed by the parent/guardian if the participant is a minor or is not legally responsible for himself or herself. **Please type or print.**

Name _____ Social Security Number _____
Height _____ Weight _____
In case of emergency, notify _____ Relationship _____
Home Phone (_____) _____ Work Phone (_____) _____

Insurance and Physician Information

Insurance company _____ Insurance policy number _____
Insurance company address and phone _____
Name coverage is in _____ Primary insured SSN _____ Primary insured DOB _____
Physician _____ Phone (_____) _____

Immunizations (Please give month/year) Tetanus ___ / ___ Polio ___ / ___ DPT ___ / ___ MMR ___ / ___

Allergies

 (Please check yes or no)

Hay fever Yes No Penicillin Yes No Sulfa Yes No Other drugs Yes No
Bee sting Yes No Poison ivy/oak Yes No Foods Yes No Other _____

Health Concerns

 (Please check yes or no)

Asthma Yes No Bed wetting Yes No Sleep walking Yes No Depression Yes No
Colds Yes No Sinus condition Yes No Sore throat Yes No Ear infection Yes No
Cramps Yes No Hyperventilation Yes No Convulsions Yes No Diabetes Yes No
Heart disease Yes No Homesickness Yes No Athlete's foot Yes No ADHD/ADD Yes No
Other _____

Please explain any of the above "Yes" responses or any other physical or emotional challenges _____

Recent illness or surgery _____ Recent exposure to communicable disease _____

Please explain any restrictions _____

Vegetarian Yes No Special dietary needs _____

Current Medications

Conference policy requires participants to turn in **ALL medications (including acne medication)**, clearly marked with name, drug, and dosage, and in its **ORIGINAL** package or bottle, to the nurse/staff under whose supervision all medications will be administered. If the participant is currently taking any medication, please provide the following information:

Medication _____ Dosage _____ Times to be taken _____
Medication _____ Dosage _____ Times to be taken _____
Medication _____ Dosage _____ Times to be taken _____

Consent and Emergency Treatment Authorization:

In the event that I cannot be reached in an emergency or I, myself, am injured or in need of emergency care, I do hereby give my consent for the above camper/counselor to receive such emergency treatment as deemed necessary by an attending physician.

Signature of Parent/Guardian/Adult Participant _____ Date _____

Please note: Over-the-counter or internally-administered medication of any kind (including aspirin and Tylenol/acetaminophen) will not be administered to minors in attendance at camp without express permission of the parent/guardian or attending physician. If you so authorize over-the-counter medication, please sign here.

Signature of Parent/Guardian _____ Date _____