

## HEALTH FORM

A completed health history is needed for all youth and adult participants. All participants must use this health form. **A physical is required only if there are any health problems or activity limitations noted in the health history on the health form.** A photocopy of a completed physical form signed by a physician and dated within the last twelve months is acceptable. If there are no health problems or activity limitations listed, a physical is not needed. Parents of participants under 18 years of age **must** complete the form.

NAME OF YOUTH EVENT: \_\_\_\_\_

NAME OF ATTENDEE: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

GENDER: MALE: \_\_\_ FEMALE: \_\_\_ GRADE COMPLETED: \_\_\_\_\_ EMAIL: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: Home: ( \_\_\_\_\_ ) \_\_\_\_\_ Work: ( \_\_\_\_\_ ) \_\_\_\_\_

IF NOT AVAILABLE, IN EMERGENCY CALL OR NOTIFY:

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_

**IN THE EVENT OF AN ACCIDENT OR INJURY REQUIRING MEDICAL ATTENTION, YOUR PERSONAL INSURANCE WILL BE CONSIDERED THE PRIMARY CARRIER.**

INSURANCE COMPANY NAME and ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

INSURED: \_\_\_\_\_ POLICY # \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ GROUP # \_\_\_\_\_

IN THE EVENT THE ABOVE NAMED YOUTH PARTICIPANT NEEDS TO SEE A DOCTOR FOR AN ILLNESS WHILE AT THE RETREAT, THE BILL SHOULD BE SENT DIRECTLY:

- Check one:     TO THE PARENTS  
                   TO THE PARENTS' HEALTH INSURANCE COMPANY

**PLEASE COMPLETE OTHER SIDE**

**HEALTH HISTORY: (Check - give approximate dates)**

- Diabetes \_\_\_\_\_
- Convulsions \_\_\_\_\_
- Rheumatic Fever \_\_\_\_\_
- Ear Infections \_\_\_\_\_
- Chicken Pox \_\_\_\_\_
- Measles \_\_\_\_\_
- Asthma \_\_\_\_\_
- Allergies: \_\_\_\_\_
- Hay Fever \_\_\_\_\_
- Penicillin \_\_\_\_\_
- Poison Ivy \_\_\_\_\_
- Insect Stings \_\_\_\_\_
- Food \_\_\_\_\_
- Other Drugs \_\_\_\_\_

OPERATIONS OR SERIOUS INJURIES (dates): \_\_\_\_\_

CHRONIC OR RECURRING ILLNESS: \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

**IMMUNIZATION HISTORY:**

Please note the date of the shots or most recent booster doses. If dates are unknown, please indicate if the person has received the immunization.

DPT SERIES: \_\_\_\_\_ BOOSTER: \_\_\_\_\_

POLIO OPV: \_\_\_\_\_ BOOSTER: \_\_\_\_\_

MEASLES: \_\_\_\_\_ SMALLPOX: \_\_\_\_\_

TETANUS BOOSTER: \_\_\_\_\_ TYPHOID: \_\_\_\_\_

.....  
**PARENTS' AUTHORIZATION: (PLEASE NOTE REQUEST FOR TWO SIGNATURES)**

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed Retreat activities except as noted by me and/or the examining physician.

In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by Prince of Peace Lutheran Church or their agents to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

\_\_\_\_\_  
**Signature of Parent or Guardian**

\_\_\_\_\_  
**Date**

**PRESS RELEASE:** I consent to the use of any photography and/or video of my child in future Prince of Peace Lutheran Church publications or on their website.

\_\_\_\_\_  
**Signature of Parent or Guardian**

\_\_\_\_\_  
**Date**

**OTHER COMMENTS FROM PARENTS:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_