

First United Methodist Church Pasadena  
Youth Health Form

Youth's name \_\_\_\_\_ Birthdate \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Youth's cell phone \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_ home phone \_\_\_\_\_ Cell \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_ home phone \_\_\_\_\_ Cell \_\_\_\_\_

Youth's Physician/Clinic \_\_\_\_\_ Phone # \_\_\_\_\_

**HOSPITAL INSURANCE INFORMATION Attach photocopy of insurance card**

Name of Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Insured's name \_\_\_\_\_ Member ID # \_\_\_\_\_

Company name if insured through employer \_\_\_\_\_ Insurance phone # \_\_\_\_\_

Persons beside parents who could be contacted to authorize treatments:

Name \_\_\_\_\_ home phone \_\_\_\_\_ Cell \_\_\_\_\_

Name \_\_\_\_\_ home phone \_\_\_\_\_ Cell \_\_\_\_\_

**List allergies, including specific nature of reaction:**

\_\_\_\_\_

**In case of an allergic reaction, respond by:** \_\_\_\_\_

\_\_\_\_\_

**List any health conditions or significant medical history that might be relevant in the event of an emergency:** \_\_\_\_\_

\_\_\_\_\_

**List any dietary needs/restrictions:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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<b>Listed are medications taken on a routine basis (medications needed on a youth outing must be provided to the designated adult, in the original container and with proper administration labeling.)</b>		
<b>Medication:</b>	<b>Dosage:</b>	<b>How often:</b>

**Attach additional list if necessary.**

<b>Permissible over the counter Medications:</b>     
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**Transportation release:** I authorize transportation for my child by emergency vehicle to an appropriate health care facility and pre-hospital medical care, all hospital and physician services, whether medical, surgical and/or dental, necessary for the benefit/safety/well-being of my child. It is my expressed intention to hold First United Methodist Church Pasadena harmless for any and all injuries, death or damages arising from or in any way related to such transportation.

**Consent to Treat:** I hereby give permission to the physician selected to order X-rays, routine tests and treatment for the health of my child, in the event I cannot be reached in an emergency. I hereby give permission to the physician selected to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my child as named above.

**The information disclosed on this form may be released to Volunteer/Staff responsible for this activity, including but not limited to youth directors, medical personnel, first aider, event coordinator, drivers.**

**I authorize the youth directors, medical personnel, counselor, pastor, etc to act in my behalf in authorizing emergency medical, dental, or surgical care and hospitalization for the above named minor in the event that I cannot be reached in an emergency.**

**Signed:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print name** \_\_\_\_\_ **Relationship to minor** \_\_\_\_\_

**Additional contact information not previously listed** \_\_\_\_\_