Participant's Name _____Birth Date _____

Lower Susquehanna Synod Medical Information Form for Minors

This form is to be filled out and signed by a parent or legal guardian for all youth under 18 years of age, when attending a synod-sponsored event. It authorizes their participation and will be used in case of a medical emergency.

Basic Information:

Parent/Legal Guardian Name: _____

Best phone # to call in case of emergency:_____Secondary Phone #: _____

Secondary Contact Name : _____

Child's Age: _____ Grade: _____Gender: _____Preferred Pronouns (optional): _____

Parent or Legal Guardian:

Your signature below gives your child permission to attend the event and authorizes the event director or their representatives to secure proper diagnosis and treatment for an emergency illness or injury from a local hospital and/or physician.

Signature of parent/legal guardian _____Date _____

Allergies: ☐ No Known Allergies ☐Food ☐Medicines ☐Environment (stings, hay, etc) ☐Other

Please describe what the participant is allergic to, and the reaction seen:

Diet/Nutrition Allergies: ☐Lactose Intolerant ☐Gluten Intolerant ☐ Special Diet (vegetarian, etc)

Please describe below any diet/nutritional needs/specifics:

Date of participant's most recent tetanus shot _____

Mental, Emotional, and Social Health: Check Yes or No for each statement.

Has the participant:

1. Been treated for Attention Defecit Disorder (ADD)? ☐Yes ☐No
2. Been treated for Attention Defecit/Hyoeractivity Disorder (ADHD)? ☐Yes ☐No
3. Been treated for emotional or behavioral difficulties? ☐Yes ☐No
4. Been treated for an eating disorder? ☐Yes ☐No
5. During the past year, been treated by a professional for mental health concerns? ☐Yes ☐No
6. Had a significant life event that continues to affect their daily life? ☐Yes ☐No
   (history of abuse, death of a loved one, family change or adoption, survied a disaster, etc)

Please explain any 'yes' answers in the space below, noting the question number.

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Is your child taking any medications? ☐Yes ☐No

We recommend working with your congregation's youth advisor, pastor, or adult accompanying your child to the event, to help distribute medications at the appropriate time to your child. Any medications should contain the child's name on the label and/or be stored in a plastic bag with the child's name on the exterior. Please list the medications below in case of an emergency.

Name of Medication	When it is given?	Amount or dose given?	How it is given?

General Health History: Check 'yes' or 'no' for your child, for each statement

Ever been hospitalized? ☐Yes ☐No

Ever had surgery? ☐Yes ☐No

Had recurring/chronic illness? ☐Yes ☐No

Had a recent infectious disease? ☐Yes ☐No

Had a recent injury? ☐Yes ☐No

Had seizures? ☐Yes ☐No

Have diabetes? ☐Yes ☐No

Had headaches, fainting or dizziness? ☐Yes ☐No

Had asthma/wheezing/short of breath? ☐Yes ☐No

Passed out/had chest pain during exercise? ☐Yes ☐No

Have problems falling asleep/sleepwalking? ☐Yes ☐No

Ever had back or joint problems? ☐Yes ☐No

Have problems with diarrhea/constipation? ☐Yes ☐No

Have any skin problems? ☐Yes ☐No

Please explain 'yes' answers below

Medical Insurance Information

Insurance Company: _____

ID# _____ Group # _____ HMO Plan ☐Yes ☐No

Name of Subscriber _____ Relationship _____

Place of Employment _____

Employer's Address _____

NOTE: In the event of an emergency illness or injury requiring medical attention, the parents' insurance will provide the primary coverage.