2017 FAITH CHURCH SUMMER CAMP

Personal Medical History Form

Please print clearly in ink

Name: ____

Address: ____

Home phone: ______________________ Cell Phones: _________________________

Date of Birth: _____________________

Name of Parent or Guardian: ____

Parent / Guardian Work Phone No.: ____

Name of Person to be Contacted if Parent / Guardian cannot be reached:

____

Phone No.: ____

Relationship to Child: ____

Child's Name: ____ Age: __________

Known allergies: ____

Is your child currently taking any medications? Yes No

If so, please list the name of the medicine and the dosage:

____

Has you child ever had any of the following ailments? (Please circle those which apply)

ASTHMA
HAY FEVER
BRONCHITIS
CHRONIC SINUS INFECTIONS
CHRONIC EAR INFECTIONS
STREP THROAT
KIDNEY INFECTIONS
ULCERS
FAINTING SPELLS
HEPATITIS
MOTION SICKNESS
HIGH BLOOD PRESSURE
HEART DISEASE
DIABETES
LOW BLOOD SUGAR
ANEMIA
MIGRAINE HEADACHES
INSOMNIA
SLEEPWALKING
MONONUCLEOSIS
FREE-BLEEDING

Has any member of your child's immediate family (birth father, birth mother, sister, brother) ever had any of the following?: (Please circle those which apply)

ALLERGIC REACTION TO MEDICINES, FOODS, ANIMALS, OR INSECT BITES
(If yes, please explain: ____)

DIABETES
HEART ATTACK
HIGH BLOOD PRESSURE
FREE-BLEEDING

List other serious medical problems occurring in the immediate family:

____

Has your child ever had surgery? Yes No

If yes, please list:____

Approximate date of surgery: ____

Has your child ever had a broken bone? Yes No

If yes, please list:

____

Does your child have any metal implants in his/her body? Yes No

If yes, please list:

____

Does your child wear contact lenses? Yes No Dentures? Yes No

Any type of bridgework, retainers, etc.? ____

DATE OF LAST TETANUS SHOT? ______________________________________

My child has my permission to ask for and take (*with the supervision of a youth leader*) any of the following over-the-counter medications indicated below:
(Please circle **yes or no** by each item listed)

Yes No Tylenol
Yes No Anti-inflammatory / Anti-cramp (Advil, Aleve)
Yes No Pepto Bismol
Yes No Cough Syrup / Coughdrops
Yes No Antacids / Anti-gas (Maalox / Mylanta)
Yes No Motion Sickness (Dramamine)
Yes No Antihistamine (Benadryl, Chlortrimeton, Tavist, Claritin)
Yes No Decongestant (Sudafed, Claritin D)
Yes No Anti-diarrhea (Imodium A-D)
Yes No Laxative (Senokot)
(Note: Generic Brands may be used)

Additional over-the-counter medicines your child may need must be turned into the Leadership Team at check-in. Please leave them in their original container and label each with your child's name.

I understand that all medicines are to be turned into the Faith EPC Summer Camp Team upon arrival at the Church. **All prescription medicines should be left in their original container with the prescription label on it.** The taking of **ALL** medicines will be supervised by a Youth Leader (the only exception to this rule will be for asthma inhalers or nitroglycerin tablets). This policy is for your child's safety and the safety of other children in the group.

Signature of Parent / Legal Guardian: ______________________________________

Printed Name of Parent / Guardian: ____

Date: ______________________________

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