



FAIRWOOD COMMUNITY UNITED METHODIST CHURCH

YOUTH HEALTH INFORMATION AND CONSENT FOR EMERGENCY CARE

| | | | | | | | |
|--|--|--|------|---|------------------|-------------------|------------|
| 15255 S.E. FAIRWOOD BLVD. RENTON, WA 98058-8645 | | PHONE (425) 228-4577 FAX (425) 228-5922 | | E-mail: youth@fairwoodumc.org joletta@fairwoodumc.org | | Last Name | |
| PERSONAL INFORMATION | | School and Grade | | Gender | Date of Birth | | First Name |
| Name | | | | | Telephone Number | | |
| Address | | | City | State | Zip Code | | |
| Custodial Parent/Guardian | | | | | Work phone | | |
| Non-Custodial Parent/Guardian (if applicable) | | | | | Work phone | | |
| ALLERGIES | | | | | | | |
| Hay Fever ____ Penicillin ____ Sulfa ____ Bee Sting ____ Poison Ivy ____ Other (name) _____ | | | | | | | |
| FOOD ALLERGIES: (Specify) _____ | | | | | | | |
| If any of the above are Yes, please submit a statement of how the youth reacts, how he/she has been treated and with what medication. | | | | | | | |
| SPECIAL NEEDS/SITUATIONS | | | | | | | |
| If your Youth has any physical, emotional, or medical limitations, please inform us to help the leaders provide appropriate support | | | | | | | |
| MEDICATIONS | | | | | | | |
| LIST ALL REGULAR MEDICATIONS AND PROPER DOSAGE. (Use other side if needed) | | | | | | | |
| IMMUNIZATIONS | | | | | | | |
| ARE IMMUNIZATIONS UP TO DATE? Yes ____ No ____ | | | | DATE OF LAST TETANUS : _____ | | | |
| DATE OF LAST PHYSICAL _____ | | | | BLOOD TYPE _____ | | | |
| INSURANCE COVERAGE | | | | Group number | | Membership number | |
| FAMILY DOCTOR | | | | | Telephone Number | | |
| EMERGENCY CONTACT (other than above individuals) | | | | | | | |
| Telephone number _____ | | | | | | | |
| CONSENT FOR EMERGENCY CARE | | | | | | | |
| I UNDERSTAND THAT, IN THE EVENT OF ILLNESS OR INJURY TO MY CHILD, EVERY EFFORT WILL BE MADE TO CONTACT ME OR THE PERSON LISTED ABOVE. IF NEITHER OF US CAN BE CONTACTED: | | | | | | | |
| I, _____ the custodial parent/legal guardian of _____ | | | | | | | |
| authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment. This release will remain in effect until September 30, 2012 unless revoked in writing. | | | | | | | |
| Parent/Guardian _____ | | | | Date _____ | | | |
| Witness _____ | | | | Date _____ | | | |
| Witness _____ | | | | Date _____ | | | |