Great Plains Conference
YOUTH EVENT HEALTH FORM

You must bring this completed form with you to the event or send with your registration.

Youth will not be allowed to stay at the event without completing and filing this form! Youth with special needs are encouraged to contact the event leadership before coming to the event.

Name: _____ SS#: _____

D.O.B.: _____ Telephone #: _____

Permanent Address: _____

Parent/Guardian - Emergency Information

Father's/Guardian's Name: _____

Address: _____

Home: _____ Cell: _____

Email: _____

Mother's/Guardian's Name: _____

Address: _____

Home: _____ Cell: _____

Email: _____

Emergency Contact Person: _____

Relationship to Youth: _____

Home: _____ Cell: _____

Email: _____

Doctor: _____ Office: _____

Last Health Examination Date: _____ (must be within past 2 years)

This individual is physically fit to participate in the event: ☐ Yes ☐ No

Doctor's Signature: _____ Date: _____

[Must have Doctor's signature if your youth is taking any medication on a regular basis, even if over-the-counter meds.]

Insured Name: _____

Insurance Company: _____ Policy #: _____

Included with this form is a copy of the Insurance Card ☐ Yes ☐ No

Check each area which applies so that our Health Supervisor will be aware of your youth's needs.

Yes	No		Yes	No		Yes	No	
( )	( )	current tetanus protection	( )	( )	history of chronic infection	( )	( )	diabetes
( )	( )	heart condition	( )	( )	skin diseases	( )	( )	fainting
( )	( )	regular medications	( )	( )	food restrictions	( )	( )	hearing aid
( )	( )	bee sting allergies	( )	( )	asthma	( )	( )	ADD/ADHD
( )	( )	convulsions/seizures	( )	( )	nose bleeds	( )	( )	bed wetting
( )	( )	wears contact lenses	( )	( )	other significant allergies	( )	( )	sleep walking
( )	( )	menstruates (females only)	( )	( )	blood disorder (explain under chronic conditions)			

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM.

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(Side 2)

Medications: List prescription, dosage, frequency. Medications brought to conference must be in ORIGINAL containers, clearly labeled, and placed in a Ziploc bag with the individual's name on it.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Drug allergies or other chronic conditions: List other conditions that require ongoing attention.

1. _____
2. _____
3. _____

Physical Restrictions: List chronic conditions that restrict activity, i.e., heart, lung, arthritis, etc.

1. _____
2. _____

Food restrictions: List food allergies, restrictions because of prescriptions, etc.

1. _____
2. _____
3. _____

I give permission for Conference staff to administer over-the-counter medications for those items checked "YES" below if the event Health Supervisor deems it necessary. Dosages will be administered according to directions on the container unless a physician directs otherwise.

Yes	No		Yes	No	
( )	( )	ear drops for swimmer's ear?	( )	( )	Caladryl lotion?
( )	( )	antacids for upset stomach?	( )	( )	Tylenol/acetaminophen?
( )	( )	cough medicine/cough drops?	( )	( )	Motrin/ibuprofen?
( )	( )	Benadryl/diphenhydramine?	( )	( )	Sudafed/pseudoephedrine?
( )	( )	Medication for diarrhea?	( )	( )	throat lozenges for soreness?

PARENT'S/GUARDIAN'S CONSENT FOR MEDICAL TREATMENT AND MEDICATIONS

I hereby give my permission to the medical personnel selected by the youth event leadership to provide routine health care; to administer medications; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide for or arrange necessary related transportation for my son/daughter. I also give my permission to release information on this form for the purpose of assisting with medical treatment.

If I cannot be reached in an emergency, I hereby give my permission to the physician selected by the youth event leadership to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for off-site event-related trips.

Parent/Guardian Signature: _____ Date: _____