

FULL NAME: _____

This information is confidential. Please complete all forms in their entirety, PRINTING LEGIBLY.

Home phone: _____

Birth Date: _____

Address: _____

Soc Sec #: _____

City/State/Zip: _____

Last Tetanus: _____

Allergies, Physical or Mental limitations, Medical conditions – diabetes, asthma, hypoglycemia: <i>(if none, state "none")</i>	
_____	_____
_____	_____
_____	_____
_____	_____

Medication currently taking or carrying:	Dosage:	Frequency:
_____	_____	_____
_____	_____	_____

Emergency Contact #1

Name
Relationship
Phone #

Emergency Contact #2

Physician: _____

Insurance Co.: _____

Office Phone: _____

Policy Holder: _____

Emergency Phone: _____

Policy #: _____

Group #: _____

Over-the-Counter Medication:

There are often times when over-the-counter medications are requested by youth. Please check those medications that WHUMC staff/sponsors may distribute to your youth. Please note that medications will not be distributed without parent/guardian permission.

___ Headache relief (Tylenol, Advil, Aleve)
___ Imodium, Tums)

___ Digestive pain relief (Pepto-Bismol, Antacid,

___ Cold, allergy, and sinus relief (Sudafed, Benadryl)

___ Motion sickness relief (Dramamine)

PLEASE ATTACH A PHOTOCOPY OF YOUR INSURANCE CARD

Any Other: