Washington Avenue Church of Christ
Student Information & Parent Permission Form

Student's Name_____ Grade_____

Student's Primary Address_____

Student's Home Phone_____

Student's Cell Phone_____

Student's e-mail _____

Mother's Name _____

Cell Phone_____ Work Phone_____

Mother's e-mail _____

Father's Name _____

Cell Phone_____ Work Phone_____

Father's e-mail_____

Insurance Information (needed in case of accident while the youth group is traveling). If you prefer, you may photocopy your insurance card, front and back, and attach it to this form.

Insurance Company_____

Policy Holder's Name_____Relationship to child_____

Group Number_____ Policy Number_____

Insurance Company's telephone number_____

Primary Care Physician's Name: _____

Phone #:_____

In the event of an emergency during activities, if I cannot be reached at one of the above numbers, the following person is authorized to act on my behalf:

Name: _____ Phone#: _____Relationship to child _____

My child, _____, has permission to participate in Washington Avenue Children or Youth Activities. He/She is in good physical condition and has not had any serious illness or operation since his/her last health examination.

Parent/Guardian Signature: _____Date:

Washington Avenue Church of Christ Student Medical Information and Emergency
Medical Authorization Form

Child Name
Last _____ First _____ Middle Initial _____

Date of Birth _____ Age _____ Gender _____ Height _____Weight

Check all medications that may be given by Health Supervisor, if needed (usually generic):

□ Acetaminophen/Tylenol	□ Ibuprophen/Advil	□ Naproxen/Aleve	□ Alcohol/vinegar drops
□ Tums	□ Anti-Nausea	□ Gas X	In ears after swimming
□ Antihistamine/Benadryl	□ Claritin/Zyrtec	□ Decongestant/Sudafed	□ Dimetapp
□ Cough Syrup/Robitussin	□ Cortizone/Anti-Itch Cream	□ Benadryl topical	□ Maalox/Antacid
□ Imodium/ Anti-diarrheal	□ Pepto-Bismol/ Bismuth	□ Stool Softener	□ Laxative
□ None	□ Other		

HEALTH HISTORY: (Check if there is any history of.)

□ Asthma	□ Hypertension	□ Sore Throats	□ Nosebleeds	□ Sleep walking
□ Convulsions	□ Heart Defect/Disease	□ Bronchitis	□ Dietary Needs	□ Sleep Disorder
□ Seizures	□ Bleeding Disorders	□ Sinusitis	□ Eating Disorder	□ Night mares
□ Fainting	□ Diabetes	□ Ear Infection	□ Constipation	□ Bed Wetting

□ Kidney Problems □ Musculoskeletal Disorders □ Stomach Upset □ Other

Please explain any checked items _____ Please list any problems related to menstruation

PAST MEDICAL TREATMENT/CONDITIONS: List & Give Dates
Operations/serious injuries _____ Hospitalizations
Other illness/disease

CORRECTIVE APPLIANCE OR DEVICE:
Does this person use or wear a corrective appliance/device for mobility, vision, hearing, dental or have a prosthesis?
□ Yes □ No If so, please explain

BEHAVIORAL, EMOTIONAL, & MENTAL HEALTH:
Are there any behavioral, emotional, or mental health conditions that may require medication, treatment, restrictions, or special consideration? □ Yes □ No If so, please list_
List any additional information about the child/youth's behavioral, physical, emotional, or mental health that staff should be aware:_
For overnight activities, is the child/youth able to change clothes, toilet, shower, and manage personal hygiene with minimal/no assistance? □ Yes □ No
Is the child/youth able to follow directions and function as part of a group? □ Yes □ No

IMMUNIZATIONS / VACCINATIONS:
Is the child/youth exempt from immunizations due to medical reasons? □ Yes □ No
(If yes, a note will be required stating reason(s) for the exemption)
If not exempt, is the camper current on all recommended immunizations and vaccinations? □ Yes □ No
Date of last Tetanus

Please list any additional information (medications, allergies, health conditions, restrictions, behavior issues, or other information) that would be useful to adults in charge of activities.

This information is accurate and complete to the best of my knowledge. The participant may engage in all activities except as noted above. I give full permission for EMERGENCY MEDICAL TREATMENT and/or anesthesia to be administered by qualified personnel as deemed necessary.

Parent/Guardian Signature: _____ Date: _____