Health Form for All Children & Youth 2024-2025

Good Samaritan United Methodist Church, Edina MN

Date Form Completed _____

Name: _____ Nickname: _____
Last First Middle

Birth Date: _____ Age: ____ Gender: ___

Street Address: _____ Parents Email: _____

Home Phone: (_____ Cell Phone: (_____) _____

City, State, Zip: _____ Youth Email: _____

HEALTH HISTORY

Please complete the following. The information provided will be used at all youth and children related activities in conjunction with Good Samaritan UMC, including: Children's events, W.I.L.D. Ones, Jr. High (BUZZ) youth group, Sr. High youth group, retreats, and other outings.

Allergies: Check all that apply to student.

❑ My student has **no** known allergies.

❑ My student has the following allergies (please list ALL allergies, including food, medication, insect, substance, latex, bee stings, or seasonal) _____

_____

Describe the reaction, and what is done to manage it: _____

_____

Diet: Check all that apply to student.

❑ My student has no restrictions.

❑ My student has the following dietary restriction(s):

❑ Vegetarian ❑ Does not eat dairy products ❑ Other: _____

Please specify _____

Chronic Concerns: Check all that apply to student and provide supportive care information.

❑ My student has **no** chronic health concerns and is capable of full participation in this program.

❑ My student has the following chronic health concern(s):

❑ Asthma	❑ Mobility difficulties	❑ Bleeding/clotting disorders	❑ Menstrual cramps
❑ Emotional disturbances	❑ Headaches		❑ Sleepwalking
❑ Fainting	❑ Heat stroke	❑ Frequent ear infections	❑ Frequent sunburns
❑ Athlete's foot	❑ Bronchitis	❑ Seizures	❑ AIDS/ HIV
❑ Diabetes	❑ Frequent colds	❑ Upset stomach	❑ Hepatitis
❑ Heart trouble	❑ Kidney trouble	❑ Poison Ivy	❑ Other: _____

Provide information about supportive health care needed for each checked item: _____

Tetanus Booster: (please list month and date of last shot) _____

Medication: Provide complete information. Please update our information if it changes through the year.

❑ My student does not take any medication on a regular basis. ❑ My student takes routine medication as

❑ Please have an adult administer all medications ❑ My student can self-medicate

Name of medication: _____ Name of medication: _____
Reason for taking: _____ Reason for taking: _____
Dose taken: _____ Dose taken: _____
Time(s) of day? _____ Time(s) of day? _____

(attach additional information if necessary)

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CONTACT INFORMATION

Parent Contact Information: We will call in an emergency or if we have any questions about your student. Provide contact information for at least three people who know your student who we may contact. We will make every effort to reach the parents first.

Parent #1 _____ #2 _____

Daytime	_____	Daytime	_____
Evening	_____	Evening	_____
Cell	_____	Cell	_____

Alternative #1 _____ #2 _____

Daytime	_____	Daytime	_____
Evening	_____	Evening	_____

Health Care Provider Information:

Name of student's physician: _____

Clinic name and city: _____ Phone: (_____)_____

Name of student's dentist/orthodontist: _____

Clinic name and city: _____ Phone: (_____)_____

Insurance Information:

Insurance Company: _____ Policy Number:_____

Preferred Hospital: _____

PERMISSIONS AND EMERGENCY RELEASE

I grant permission for _____ to participate in all Good Samaritan United Methodist Church (The "Church") activities and overnights for the 2023-2024 school year. (June 1, 2024 - May 31, 2025). I warrant that my student is in good health. In consideration of my student's participation, I agree to indemnify the church and The Minnesota Annual Conference of the United Methodist Church (The " Conference") against any claim of any kind that arises out of any behavior or actions by my student at these events. I (individually and on behalf of my student), so hereby release, discharge, and absolve the church, the conference, their agents and employees from any claim of any kind which we might have by reason of any damage to property or personal injury occurring during the period of time our student is participating in these activities.

Signature of parent / guardian: _____Date: _____

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Authorization for Emergency Health Care: I, hereby give my permission to the licensed physician selected by the activity leadership, to order and/or administer proper treatment and medical care, routine tests, X-rays, anesthesia, injections, surgery, and/or secure hospitalization for my student named on this form and to release necessary medical information for insurance purposes. A photocopy of this completed form shall be valid as the original. In the event of an emergency, activity leadership will make every effort to reach the parents as soon as possible.

Signature of parent/guardian: _____ **Date:** _____

Authorization for Routine Health Care: My student is allowed to take/use the following medications under the supervision of an adult leader:

❑ Tylenol ❑ Advil ❑ Benadryl ❑ Pepto Bismol ❑ Antacids ❑ Antibiotic Ointment

Signature of parent/guardian: _____ **Date:** _____

Activity leadership is authorized to perform Basic First Aid as deemed necessary.

PLEASE LIST EXCEPTIONS or SPECIFIC REQUESTS: _____

_____

Participation Permission: This health history is correct so far as I know. My student, described herein, has permission to engage in all prescribed church activities except as noted by me and/or an examining physician. I understand that some activities are strenuous and some involve a risk of accidents which may result in serious bodily injury or harm to my student.

Signature of parent/guardian: _____ **Date:** _____

Multi-Media: I understand that photos (film, video, digital images) taken of my student may be used by Good Samaritan United Methodist Church in publications such as newsletters.

I give my permission for this. YES_____ NO _____

E-Mail: I give Good Samaritan United Methodist Church permission to send e-mails to my student:

YES _____ NO ____

Text-Phone Permission: If my teenager has a cell phone, I give permission for Jan Russell to communicate directly by text or phone call.

YES ____ NO ____ N/A ____

Signature of parent/guardian: _____ **Date:** _____

Please send all completed forms to Good Samaritan UMC, 5730 Grove Street, Edina, MN 55436;

%Jan Russell (Director of Children, Youth and Families Ministries) jan@good.org