Second Baptist Church
Youth Health Form 2019

Name ______________________________ Date __________

Birthday __________________ Age: ________ Gender: Male Female

Parent / Guardian(s) ______________________________ Home Phone __________

His Work Phone __________ His Cell Phone __________ Her Work Phone __________ Her Cell Phone __________

Home Address ______________________________
Street Address City State Zip

Parent Email ______________________________

BACKUP EMERGENCY CONTACT ______________________________ Relationship: __________
*Must be someone who does not live with the participant

Home Phone __________ Cell Phone __________ Work Phone __________

Home Address ______________________________
Street Address City State Zip

Is there anyone NOT authorized to pick up the participant from an event?

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Participant's Physician ______________________________ Phone __________

Participant's Dentist/Orthodontist ______________________________ Phone __________

HEALTH HISTORY

(Explain "yes" answers below)

Has/does the participant:

		YES	NO
1.	Have a chronic or recurring illness/ condition?...	☐	☐
2.	Have frequent headaches?.....................	☐	☐
3.	Ever had a head injury?...........................	☐	☐
4.	Ever been knocked unconscious?...	☐	☐
5.	Wear glasses, contacts, or protective eyeware?...	☐	☐
6.	Have frequent ear infections?.................	☐	☐
7.	Ever had seizures?....................................	☐	☐
8.	Ever had high blood pressure?.................	☐	☐
9.	Have diabetes?..	☐	☐
10.	Have asthma?..	☐	☐
11.	Had mononucleosis in the past 12 months?..	☐	☐
12.	Have problems sleepwalking?..................	☐	☐
13.	Ever had an eating disorder?....................	☐	☐

Please explain any "yes" answers. Attach a separate sheet of paper if necessary. ______________________________

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Please explain any dietary restrictions. ____

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Please explain any activities restricted by a physician. ____

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Please explain any additional health information we need to know. Attach a separate sheet of paper if necessary.

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____

What is the participant's swimming ability? ☐ Nonswimmer ☐ Swimmer ☐ Strong Swimmer

Does the participant take any medications, prescription or non-prescription, regularly? ☐ Yes ☐ No
If yes, the Medication Form must be filled out.

What is the date of the particpant's last Tetanus shot? ______________________

ALLERGIES

Medication Allergies	______________	Reaction and Treatment	______________
	______________		______________
Food Allergies	______________	Reaction and Treatment	______________
	______________		______________
Other Allergies (plant, insect, animal, etc.)	______________	Reaction and Treatment	______________
	______________		______________

MEDICAL INSURANCE

Is the participant covered by family medical/ hospital insurance? ☐ Yes ☐ No

Insurance Carrier ______________________ Policy # ______________________