CHILDREN & YOUTH HEALTH FORM

For children, youth and volunteers under 18 years of age

PLEASE COMPLETE BOTH SIDES OF THIS FORM BY READING THE INSTRUCTIONS CAREFULLY. ALL INFORMATION IS VERY IMPORTANT TO INSURE THAT YOUR YOUTH HAS A POSITIVE EXPERIENCE. COMPLETE INFORMATION REGARDING MEDICATION IS NECESSARY.

❖ Current weight is vital for correct medication in an emergency	❖ Insurance information is important in case of an emergency
❖ Be sure to note Seasonal Allergies and Allergic Reactions. If there are none, write "None"	❖ Youth must have a closed toe and heel shoes for general wear
❖ Medications must be noted or we will be unable to dispense medications to your youth	

Youth Name: _____Birth Date: _____ Age: _____ Sex: _____ Current Weight: _____

Parent/Guardian: _____ Hm Phone: _____ Wk/Cell Phone: _____

Residence Address: _____City_____ State _____ Zip Code: _____

In an emergency notify (other than above)_____ Phone:_____

Address:_____City:_____ State: _____Zip: _____

Family Doctor in case detailed medical history is needed: _____ Phone:_____

Insurance Information:

Insured's Name: _____ Emp .ID #_____ Policy No: _____

Medical Insurance Co: _____ Group Subscriber's Name: _____

Insurance Phone: _____

Parent(s) or Guardian(s) will be notified of any emergency or unusual health care issue.

HEALTH HISTORY: Check –give dates	Date		Date		Date
Abscessed Ears		Constipation		Rheumatic Fever	
Allergies (seasonal)		Diabetes		Scarlet Fever	
Appendicitis		Diphtheria		Serious IVY, Sumac Poisoning	
Asthma		Fainting		Sinusitis	
Athlete's Foot		German Measles		Sleep Walking	
Bed Wetting		Heart Trouble		Sore Throat (frequent)	
Bronchitis		Kidney Trouble		Stomach Upset	
Chickenpox		Measles		Tonsillitis	
Colds (frequent)		Mumps		Tuberculosis	
Convulsions or Epilepsy		Pneumonia		Whooping Cough	
Operations or Serious Injuries:					
Emotional/Behavioral/Learning Concerns:					

Immunizations and date of last Booster:									
Measles		Tetanus		Hepatitis B		Polio		Rubella	

Allergic Reactions:							
Bee Stings:		Aspirin		Other Drugs		Foods:	Other:
Penicillin		Tylenol					

Medications – Over the Counter: If it is necessary to give medication to my child, I prefer: List Dose for appropriate for age.

Over the Counter Med	Dosage	Over the Counter Med	Dosage	Over The Counter Med	Dosage
Tylenol		Antacids		Antihistamine (Name)	
Nuprin/Advil					

Medications - Prescribed

In order to provide the safest possible delivery of your youth's medication(s), please be sure that the medication(s) is/are labeled with the following: a) youth's name: b) Name and dose of drug: c) current directions for giving the medication, including time to be given and any special instruction (s) i.e. "give with food", etc. **Sending Medications(s) in original containers with the above information is mandatory.**

Drug Name:	Dose	Direction (with food)
Activity Restrictions:		
Heart/Other Handicap condition:		
Specify Special Needs:		

Health Screening – This section to be completed by Camp Nurse at Campsite. Examination necessary only for a "YES" answer.

Sore Throat:	Ear Ache:	Rash:	Itchy Scalp/Lice:	Athlete's Foot:
Recent exposure to:	Measles:	Mumps:	Chicken Pox:	
Review of Medication(s) brought to camp: YES NONE		Logged on routine Drug From: YES		
Ask: "Are you generally healthy now?" YES NO				
Comments:				
Camp Nurse:		Date/Time:		

Legal Guardian's Signature_____ **Date:** _____

CONSENT FOR MEDICAL TREATMENT
AND SPECIAL POWER OF ATTORNEY

This Consent for Medical Treatment and Special Power of Attorney meets the needs as interpreted in current Arizona and Nevada law. Current law interpretation requires that the form be notarized and must be witnessed by a third party. This Consent for Medical Treatment and Special Power of Attorney is valid for **SIX MONTHS**. A photocopy or fax of this form has the same validation as the original.

Youth Participant Name: _____

The undersigned parent(s) or legal guardian(s) of the above-named Youth Participant do hereby appoint the Desert Southwest Annual Conference of The United Methodist Church (the "Conference") as attorney-in-fact with full power to act in the place and stead of the undersigned, in connection with any and all activities sponsored by Conference or any of its agencies in which the Youth Participant may be engaged, for the purpose of providing, authorizing and making all decisions concerning medical treatment for the Youth Participant, including without limitation emergency medical care and safety of the Youth Participant during or in transit to or from the Conference-sponsored activity. The Conference may exercise this special power of attorney from time to time through any of its designated adult employees or agents and may demonstrate the existence of the authority granted hereby the presentation of either the original or photocopy of this Consent for Medical Treatment and Special Power of Attorney. The undersigned consent to all such medical treatment and take full responsibility for any financial cost, which may be incurred in connection with the medical treatment of the youth Participant.

Dated this _____ day of _____, 20_____

_____

Parent(s)/Guardian(s) Signature(s) Home Phone

_____

Address Alternate Phone

Subscribed and sworn before the undersigned notary public of the State of _____

County of_____, this _____ day of _____, 20_____

_____ My commission Expires: _____

Notary Public

MAKE COPIES

- Take one copy to event
- Give one copy to your youth coordinator/leader/director
- Keep one copy for use at future events
- It is no longer necessary to mail a copy to the Conference Office