East Lake United Methodist Church
2018 HEALTH FORM AND MEDICAL RELEASE

Personal Information—PLEASE PRINT CLEARLY

Name _____Birth Date _____Age _____Sex____
Last First Initial

Home Address_____
Number and Street City State Zip

Parent or Guardian _____Home Phone ( )_____

Work Phone ( )_____ Cell Phone ( ) _____

Second Parent or Guardian or Emergency Contact_____

Home Address_____
Number and Street City State Zip

Work Phone ( )_____ Cell Phone ( )_____

If not available in an Emergency, notify:
Name _____ Relationship _____

Home Phone ( )_____ Work Phone ( )_____

Cell Phone ( )_____

Health Information

Frequent Ear Infection_____
Hay Fever_____
Ivy Poisoning_____
Chicken Pox_____
Diabetes_____
Penicillin_____
German Measles_____
Disorders_____
Asthma_____
Mononucleosis_____
Heart Defect Disease_____
Convulsions_____
Bee/Insect Stings_____
Measles_____
Bleeding/Clotting_____
Other Drugs_____
Mumps_____
Hypertension_____

What treatment is required for Asthma _____
Operations or serious injuries (dates) _____
Dietary Modifications_____
Current Medications (send with instructions) _____
Food Allergies_____
Drug Allergies_____
Other Allergies_____
What treatment is required for allergy?_____
Any other health issues that we should be aware of?_____
Date of Last Tetanus Shot (required) _____

May adults in charge administer (circle) Aspirin – Y/N Acetaminophen – Y/N Ibuprofen – Y/N
Antacid – Y/N Antibiotic Ointment – Y/N Benadryl – Y/N Cortisone Cream – Y/N Midol – Y/N

Name of Family Physician_____

Address_____

Number and Street City State Zip

Phone number_____

Name of Dentist_____

Phone Number_____

Insurance Coverage

Insurance Company_____ Phone ( ) _____

Policy Number:_____ Group #_____

I hereby give permission to the Physician selected by the adult in charge of the East Lake United Methodist Church/Children's or Youth Activity to order X-Rays, routine tests and treatment for the health of my child, and in the event that I can not be reached in an emergency, I hereby give permission to the Physician selected by the adult in charge to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for my child as named above.

Parent or Guardian Signature _____Date_____

STATE OF FLORIDA: COUNTY OF PINELLAS

The foregoing instrument was acknowledged before me this _____ day of _____, year 20____. By _____, who is personally known to me or who has produced _____ as identification and who did not take an oath.

_____
Signature of Notary

_____
Name of Notary, printed or stamped

Notary Public

_____
(Serial Number, if any)