

**St. John's Episcopal Church
Barrington, RI
Youth Medical Information**

Participant's name: _____

Current status of participant's health: _____

Is the participant allergic to any medication/food/ insect/etc.? YES NO

If yes, please list. _____

List any medications the participant is currently taking, or state none. _____

List any medical conditions of which we should be aware. _____

Name of participant's doctor: _____ Phone number: _____

What is the date of participant's last tetanus toxoid immunization? _____

Please check any of the following over-the-counter medications the participant **should not** be given.

- | | |
|-------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Antihistamines |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Decongestants |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Maalox Antacid |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Imodium Anti-Diarrhea |
| <input type="checkbox"/> Antiseptic cream or ointment | <input type="checkbox"/> Kaopectate |
| <input type="checkbox"/> Pepto-Bismol | <input type="checkbox"/> Other (Please Specify) |
| <input type="checkbox"/> Hydrocortisone cream | _____ |

List any activities from which the participant should be restricted. _____

List any foods the participant is allergic to. _____

Is the participant under treatment for any chronic or current emotional problems? YES NO

If yes, please explain. _____

Is there anything not covered in these questions that you would like to share with us? (Please use back of form.)

Insurance Information

Name and contact information for company with which you have coverage: _____

Group/Individual Policy Number _____ Identification Number _____

Parent's Authorization

I understand that the St. John's Church does not provide medical/accident insurance coverage for my child, and I accept the responsibility to provide any needed coverage. Further, in the event an injury should occur and require medical assistance, I give permission to any physician to render appropriate medical care, hospitalize, and order anesthesia and/or surgery as deemed necessary. I also give permission for the adult mission leaders to administer any over-the-counter medication my child may need during this trip.

Parent/guardian's signature: _____ Relationship: _____

Date: _____

Phone number where you can be reached during this event: We would like a few different options in case of emergency:

1. _____ 2. _____ 3. _____