

Name (Last) (First) (MI) (Age)

Contact Information

Father _____ Mother _____

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____

Father's Cell Phone _____ Mother's Cell Phone _____

Friend or Relative _____ Phone _____

Child's Doctor _____ Doctor's Phone _____

Parents are _____ married _____ separated _____ divorced

Custodial parent is _____

Child lives at home with _____

Cell Phone

Allergies

Drugs _____

Foods _____

Latex or other allergies _____

Vaccines

Tetanus (date) _____ Hepatitis B (date) _____

Medications (dosage, frequency) _____

Hospitalizations / Surgeries (list) _____

Last

Birth Date _____ Height _____ Weight _____

Middle

Medications

Place a check by any of these over the counter medications your child may receive. Note – These medications will be given by an adult chaperon. We prefer that an adult be notified if your child is traveling with any medicines (over the counter, prescription, etc.).

First

 Tylenol (acetaminophen)

 Mylanta / Maalox / Tums / Rolaids (antacid)

 Advil / Motrin (ibuprofen)

 Zantac (ranitidine)

 Benadryl (diphenhydramine)

 Other _____

Nickname

 Imodium (loperamide hcl) _____

 Sudafed (phenylephrine) _____

Pepto Bismol (bismuth subsalicylate)

Name (Last) (First) (MI) (Age)

Medical History

Additional information may be typed and attached

Eyes

- Contacts
- Glasses

Ear, Nose, and Throat

- TMJ
- Other _____

Heart

- Heart Murmur
- Mitral valve prolapse
- Family history of sudden death
- Other _____

Lung

- Asthma (list medications)
- Other _____

Gastrointestinal

- Reflux
- Irritable Bowel Syndrome
- Other _____

Neurological

- Seizures
- Fainting Spells
- ADD / ADHD
- Eating Disorders
- Other _____

Orthopedic

- Chronic bone / joint problems
- Previously broken bones (list as necessary)
- Other _____

Hematological

- Anemia
- Free Bleeding
- ITP
- Leukemia / Cancer
- Other _____

Endocrine

- Diabetes (How long? List insulin type, dose, frequency.) _____ years
- Thyroid
- Other _____

Kidney

- Kidney problems

Other Health Problems Not Listed _____

Name (Last) (First) (MI) (Age)

Insurance

Please include a copy of card

Company _____

ID Number _____

Group number _____

Subscriber _____

Subscriber birth date _____

I understand that this information will be released to Brandon Edwards and/or other agents of Riverchase

Church of Christ. I _____ authorize the agent of Riverchase Church of Christ to seek emergent or non-emergent medical care on behalf of my child

_____ as deemed necessary. I also allow them to receive information regarding the treatment, care and condition of my child.

Printed Name

Signature