### Health History Form Dates of Attendance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## All Participants Name of Event \_­Border Immersion Program\_\_\_\_\_\_\_\_\_\_\_\_

**Iglesia Luterana Cristo Rey**

This form (front & back) should be filled out by each participant. Attach

additional pages if needed. Any changes to this form should be provided

to the event health personnel **in writing** upon participant’s arrival at the event.

Group leaders must carry completed forms at all times during the event.

**Participant’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle Initial

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex (circle one) **Male Female**

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone ( )­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Other Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parents/Guardian’s Name(s)** – If 17 or younger \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle Initial

Relationship to Participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone ( )­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Other Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Emergency Contact Information

Primary Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day-time Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day-time Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History** – Check and date any of the following applicable to the participant or the participant’s family

ConditionsDiseasesAllergies

\_\_\_ Alcohol/Drug Addiction \_\_\_ Frequent Sore Throats \_\_\_ Chicken Pox \_\_\_ Hay Fever

\_\_\_ Asthma \_\_\_ Headaches \_\_\_ German Measles \_\_\_ Insect Stings

\_\_\_ Attention Deficit Disorder \_\_\_ Heart Disease/Defect \_\_\_ Measles \_\_\_ Ivy Poisoning

\_\_\_ Back pain or strain \_\_\_ Hypertension \_\_\_ Mumps \_\_\_ Penicillin

\_\_\_ Bleeding/Clotting Disorders \_\_\_ Menstrual Problems \_\_\_ Other Drugs

\_\_\_ Diabetes \_\_\_ Mononucleosis \_\_\_ To Food Items

\_\_\_ Epilepsy/Seizures \_\_\_ Psychiatric Counseling \_\_\_ Other

\_\_\_ Frequent Ear Infections \_\_\_ Other

Please explain each item checked \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pertinent past medical treatment – please list with dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any dietary restrictions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the participant presently taking or using any type of medication(s) or drug(s)? \_\_\_ Yes \_\_\_ No

 If yes, please specify and complete medications report on reverse side \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the participant current on all immunizations? \_\_\_ Yes \_\_\_ No Blood Type (if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last immunization: Tetanus: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Polio: \_\_\_\_\_\_\_\_\_\_\_\_\_ Measles: \_\_\_\_\_\_\_\_\_\_\_

Does the participant have a health condition (i.e. allergies, chronic conditions) or special circumstances which may affect program participation, special housing needs, or anything the event health personnel ought to know prior to emergency treatment? \_\_\_ Yes \_\_\_ No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical/Hospital Insurance** \_\_\_ Yes \_\_\_ No Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( )­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Dentist/Orthodontist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( )­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Continued on Reverse

**Parent/Guardian Authorization (If 17 or younger)**

My child has permission to take part in all event activities under supervision unless limitations are noted above, and I agree that the event personnel will not be held responsible for accidents arising there from. I hereby give permission to the event coordinators to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the event coordinators to arrange necessary related transportation for my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the event coordinators to hospitalize or secure proper treatment (including surgery, injection, and/or anesthesia) for the person named above. This completed health form may be photocopied for trips out of the event location.

**Signature of Parent/Guardian** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Witness** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Participant** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Adult Participant

I hereby permission to the event coordinators to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the event coordinators to arrange necessary related transportation for me.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the event coordinators to secure and administer treatment, including hospitalization, for the person named above. This completed health form may be photocopied for trips out of the event location.

**Signature of Participant** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Permission to Administer Medications Dates of Attendance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## All Participants Name of Event \_­Border Immersion Program\_\_\_\_\_\_\_\_\_\_\_\_

Iglesia Luterana Cristo Rey

I, the parent or guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my permission to the event health care provider or his/her designate to give the following medications (or their generic equivalents) to my child, in accordance with recommended package dosing for the specific indications below. These medications are available at the event and need not be brought by participants.

 Yes No Yes No

**Tylenol** – *Mild fever or discomforts* **Antacid** – *Upset stomach*

## Ibuprophen – *Mild fever or discomforts* Anti-diarrheal – *For diarrhea*

**Throat Lozenges** – *Cough/sore throat* **Topical Creams** – *Itching,*

 *sunburn, or insect bites*

**Benadryl** – *Allergy symptoms*

 **Permission to follow**

**Sudafed –** *Allergy symptoms* **recommendations by Texas, Mexico, or New Mexico Poison Control Center**

**Signature of Parent/Guardian** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last for the entire event. Keep medications in their original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

Medication #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specific times taken each day \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Reason for taking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specific times taken each day \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Reason for taking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication #3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specific times taken each day \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Reason for taking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Attach additional page for more medications.*

NOTE: The event personnel will notify parent(s)/guardian(s) if the participant displays the following symptoms:

* Any illness that persists longer than 24 hours; including fevers, coughs, excess expulsion of bodily fluids, allergic reactions, severe tiredness.
* Any injury that causes severe prolonged pain, discoloration and/or swelling.
* Any condition that cannot be sufficiently treated by event personnel.
* Any condition requiring transport to other medical services.

###### Upon Check-In

Health History Form Verified \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 Date Initials

Health History Form Updated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 Date Initials