Health History Form

All Participants
Iglesia Luterana Cristo Rey

Dates of Attendance _____
Name of Event _Border Immersion Program_____

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

Conditions
___ Alcohol/Drug Addiction
___ Asthma
___ Attention Deficit Disorder
___ Back pain or strain
___ Bleeding/Clotting Disorders
___ Diabetes
___ Epilepsy/Seizures
___ Frequent Ear Infections
___ Frequent Sore Throats
___ Headaches
___ Heart Disease/Defect
___ Hypertension
___ Menstrual Problems
___ Mononucleosis
___ Psychiatric Counseling
___ Other

Diseases
___ Chicken Pox
___ German Measles
___ Measles
___ Mumps

Allergies
___ Hay Fever
___ Insect Stings
___ Ivy Poisoning
___ Penicillin
___ Other Drugs
___ To Food Items
___ 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

All Participants

Iglesia Luterana Cristo Rey

Dates of Attendance _____

Name of Event Border Immersion Program

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*	☐	☐			
Sudafed – *Allergy symptoms*	☐	☐	**Permission to follow 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 _____ (Date) by _____ (Initials).

Health History Form Updated _____ (Date) by _____ (Initials).