Lighthouse student ministry
Heritage United Methodist Church

Health Form

Name: ____ Age: ____ Grade: ____ Sex: ____
Last First M.I.

School Attending: ______________________________ Birth Date: _____________________

Home Phone #: (____)_____________________ Student Cell #: (____)___________________

Home Address: ____

Church Attending: _________________________ E-mail: ______________________________

1. Parent/Guardian: __________________________ Phone #'s: H)____________ C)_____________

   Parent/Guardian E-mail: ____

   Business Name/Address: ____________________________________ Phone #: _______________

2. Parent/Guardian: __________________________ Phone #'s: H)____________ C)_____________

   Parent/Guardian E-mail: ____

   Business Name/Address: ____________________________________ Phone #: _______________

In an emergency, if not available, please notify:

Name: ____________________________________ Phone #'s: H)____________ C)_____________

Address: ____Relationship _____________________

Health History

Date of Last Tetanus Shot: ____

*Any other allergies? ____

Treatment required for allergy or asthma? ____

Operations or serious injuries (dates & descriptions): __________________________________

____

Dietary Modifications? ____

Current Medications: (send with instructions) ____

Other ailments or comments: ____

Frequent Ear Infections	_____	Mononucleosis	_____	Hay Fever	_____
Heart Defect/Disease	_____	Chicken Pox	_____	Asthma	_____
Convulsions	_____	Measles	_____	Allergic to:	
Diabetes	_____	German Measles	_____	Poison Ivy/Oak	_____
Bleeding/Clotting	_____	Mumps	_____	Bee/Insect Sting	_____
Disorders	_____	Headaches	_____	Penicillin	_____
Hypertension	_____	Hypertension	_____	Sulfa	_____
				Other Drugs __________	

May adults in charge administer:

Aspirin?	___ Yes	___ No	Tylenol?	___ Yes	___ No
Advil?	___ Yes	___ No	Benadryl?	___ Yes	___ No

Physician Information:

Name of Student's Physician: ____

Address: ______________________________________ Phone: ___________________________

Insurance Coverage:

Insurance Company: _____________________________ Phone: ___________________________

Policy/Group #'s: ____

Other Information Needed: ____

Granted Permission:

I hereby give permission to the physician selected by the adult in charge of the Heritage UMCSM to order x-rays, routine tests and treatment for the health of my child, and in the event that I cannot 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, ______________________. I agree to hold the adult in charge free and harmless of any claims, demands, or suits for damages arising from the giving of such consent.

I also give my permission for use of photographs/videos taken of my student to be used on the Church website or any other promotional literature.

Parent or Guardian Signature: ____

Form must be signed in the **presence** of a notary.

Date signed: _________________

STATE OF FLORIDA,
COUNTY OF PINELLAS

The foregoing instrument was acknowledged before me this _______ day of ______________________, 201___, 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)

____
(Serial Number — if any)