Trinity Episcopal Church

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Health Information Form – 2007-2008 Program Year

Teen's Full Name ____________ Date of Birth ____________ Gender (M / F)

Street Address ____________ City and Zip ____________

Parent/Guardian #1 Full Name ____________ Parent/Guardian #2 Full Name ____________

Street Address ____________ City and Zip ____________

Parent/Guardian #1 Phone numbers (please list home, cell, work) ____________

Parent/Guardian #2 Phone numbers (please list home, cell, work) ____________

Preferred parent/guardian to contact first _____ Parent #1 _____ Parent #2 _____ Doesn't matter

Another Adult to Contact in Case of Emergency ____________ Relationship ____________

Secondary Contact Phone numbers (please list home, cell, work) ____________

Health Insurance Company ____________ Policy/Group # ____________

Teen's Doctor ____________ Doctor's Phone Number ____________

Name of Teen's School ____________ Grade in School ____________

*** Please fill out the reverse side of the page ***

Teen's Full Name

Please be as specific as possible in filling out the form below. This information is held in confidence and will be shared only with medical providers as needed.

Date of teen's last tetanus shot Wears glasses/contacts?

Allergies (include type of reaction and severity of reaction):

Food concerns/sensitivities (vegetarian, celiac, lactose intolerant, etc):

Medications taken regularly (include reason for medication)

**** If your teen will be bringing medication to an overnight event, please inform the adult leaders.****

Please note: The leaders will dispense ALL medications at overnight events, including over-the-counter medications (such as pain relievers, antacids, cough syrup, etc.).

Other health concerns or limitations