New York Conference Youth Ministries Department

Medical Record/Consent to Treat Form

Name: ______________________________ Birth date: __________ Age: ______ Sex: _____ Home Phone: ______________
Parent/Guardian: _______________________ Home Address: ____
Cell Phone: ___________________________ Email: ____
Other Parent/Guardian: __________________ Home Address: ________________________ Home Phone: _______________
Cell Phone: ___________________________ Email: ____

In the event of emergency, and parent or guardian cannot be reached, notify: _______________________________________
Relationship to Child: ____________________ Address: ____
Home Phone: __________________________ Business/Cell Phone: ______________ Email: ___________________________

Medical Insurance
Policy Holder's Name: ____
Insurance carrier and type of coverage: ______________________________ Policy No.: ___________ Group No.: ___________
Authorization for release for information to above named insurance carrier:
Signature: ________________________________ Date: _____________ Relationship to child: __________________
Address of Insurance Company: ____

Health History – To be completed by PARENT/GUARDIAN (give approximate date of illness or "no" if not applicable)

___ frequent ear infections ___ hypertension ____ bleeding/clotting
___ heart defect/disease ___ psychiatric treatment ____ bed wetting
___ convulsions ___ mononucleosis ____ fainting
___ diabetes ___sleep walking ____ asthma
___ chicken pox ___ measles ____ German measles
___ mumps

Allergies
___ hay fever ___ plants
___ insect stings
___ food: _________________________
____

Operations or serious injuries (dates): _________________________ Disability of chronic or recurring illness: ________________
Medication Allergies: ____
Current medication *(send in original container with instructions)*: ____
Dietary modifications: ____
Any specific activities limited: ____
Name of dentist/orthodontist: ____ Phone: _____________________
Name of family physician: ____ Phone: _____________________

Immunization History – Must be completed with dates. Please record the date (month and year) of basic immunizations and most recent booster doses or provide a copy of record:

____ DPT or DT ____ Tuberculosis ___ Polio vaccine (most recent) ___ Other tetanus ___ Flu vaccine
____ MMR ____ Pneumonia vaccination ___ Hepatitis vaccination ___ Recent exposure to contagious disease

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The information given by me on this form is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed activities, except as noted by me. In case of emergency, I understand that every reasonable effort will be made to contact me. In the event that I cannot be reached, I hereby give permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for the person herein described.

Signed: ____________________________________ Date: ____________ Relationship to child: ______________________