

NORTHERN HILLS UNITED METHODIST CHURCH 2026

THIS FORM MAY BE PHOTOCOPIED WHEN COMPLETED. PRINT CLEARLY. USE BLACK INK.

NAME _____
Last First Middle Home phone

ADDRESS _____ **CITY** _____ **ZIP** _____

_____/_____/_____
Date of Birth Grade School **Youth Cell Phone** _____

Youth's Doctor /Clinic Doctor's Phone

Date of Last: Health Exam _____ T.B. test

SHOT RECORD: _____ Hepatitis A _____ Hepatitis B _____ Tetanus Shot

Father's Name Work Phone Cell Phone

Mother's Name Work Phone Cell Phone

Alternate Emergency Contact Name Day Phone Evening Phone Relationship

HEALTH HISTORY: (CHECK THOSE THAT APPLY)

DRUG ALLERGIES: _____

OTHER ALLERGIES: ____ Animals ____ Food ____ Insect stings ____ Plants ____ Pollen ____ Other

If any checked please explain: _____

CHRONIC OR RECURRING ILLNESS:

____ Ear infections ____ Contact lens wearer ____ Heart defect/disease ____ Seizures ____ Bleeding disorder

____ Asthma ____ Diabetes ____ Other (specify) _____

SURGERIES, INJURIES OR OTHER HEALTH ISSUES: _____

IN THE LAST YEAR: (ANSWER YES OR NO)

Have you been out of the USA in the last year? _____

Complicating medical problems/operations? _____ Serious injury/illness requiring medical care? _____

Please explain: _____

SPECIFIC INSTRUCTIONS CONCERNING MY CHILD'S CARE: _____

HOSPITAL INSURANCE INFORMATION: * *Please attach photocopy of insurance card*

Name of Carrier Policy Number

Group Number

Insured's Name

Company Name (if insured through employer)

FAMILY MEMBER (S) WHO MAY BE CONTACTED IN CASE OF EMERGENCY TO AUTHORIZE TREATMENTS:

Name

Day Phone

Evening Phone

Relationship

Name

Day Phone

Evening Phone

Relationship

MEDICAL TREATMENT AUTHORIZATION

I (we) understand that in the event the child named above is injured while in the care of Northern Hills United Methodist Church and requires the attention of a doctor, the Director of Student Ministries, and/or representatives of Northern Hills United Methodist Church will make every effort to contact us. If I (we) cannot be reached by telephone at one of the numbers listed above, or if because of an emergency, there is not time or opportunity to make a telephone call, I (we) hereby authorize the Director of Student Ministries, and/or representatives of Northern Hills United Methodist Church to give consent on my (our) behalf for emergency medical treatment. In the event that it becomes necessary for a representative of Northern Hills United Methodist Church to give consent on our behalf they are authorized:

1. To have access to any and all medical and related information and records.
2. To disclose medical and related information to others.
3. To employ and discharge medical and related personnel.
4. To consent or refuse consent to medical care and emergency medical procedures.
5. To provide appropriate relief from pain.
6. To arrange for care and lodging in a hospital.
7. To grant releases to health care professionals or institutions to assure that the wishes of the parent/guardian are fulfilled.
8. To take immediate physical custody and possession of the child that is the subject of this authorization in the absence of the ability of the parent/guardian to do so, and to provide for the care and physical custody thereof during such absence.

Parent Signature

Date