Youth Ministry Registration

Please complete this form for each student participating in Youth Ministry.

CHILD's NAME: (Last)________________________(First)___________________

BIRTH DATE:________________MALE:__________ FEMALE:_____________

HOME ADDRESS:____

CITY/STATE/ZIP:____

DAY PHONE: ( )____________ __EVE PHONE: __( )________________

E-MAIL ADDRESS: ____

CUSTODIAL PARENT(S)_/ GUARDIAN:__________________________________

HOME PHONE: (____)_____________ MOBILE PHONE:__(____)_____________

HOME ADDRESS: (if different)____

HEALTH PLAN CARRIER: ____

NAME OF INSURED:____

RELATIONSHIP TO POLICYHOLDER:___________________________________

POLICYHOLDER/INSURANCE ID:_____________________________________

FAMILY DOCTOR: ____

OFFICE PHONE: (_____)______________

FAMILY DOCTOR:____

OFFICE PHONE: _(_____)_______________

EMERGENCY CONTACT:____

RELATIONSHIP TO PARTICIPANT: _____________________________________

HOME PHONE: (____)________________DAY PHONE:__(____)______________

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Medical Information

Please complete this form so health providers can be aware of your child's health needs.

CHILD'S NAME:____

Does child have: (If "Yes", explain)

______YES_________NO__________ALLERGIES?____________________

______YES_________NO__________HEART CONDITION?_____________

______YES_________NO__________DIABETES?_____________________

______YES_________NO__________OTHER?_______________________

Is child subject to: (If "Yes", explain)

______YES_________NO__________HEADACHES?__________________

______YES_________NO__________SEIZURES? ___________________

______YES_________NO__________MOTION SICKNESS?____________

______YES_________NO__________FAINTING?____________________

______YES_________NO__________UPSET STOMACH?_____________

______YES_________NO__________OTHER?______________________

Does child have reaction to: (If "Yes", explain)

______YES_________NO__________BEE STING?____________________

______YES_________NO__________PENICILLIN?____________________

______YES_________NO__________OTHER DRUGS?________________

______YES_________NO__________POISON IVY, OAK, SUMAC?_______

______YES_________NO__________PEANUTS_?____________________

______YES_________NO__________OTHER?_______________________

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Does child have any condition that would prevent him/her from participating in any of the activities of this program?

______YES_________NO____

Does child take any prescription medications?

______YES_________NO____

Does child have any sight or hearing impairment?

______YES_________NO____

Does the child wear contact lenses?

______YES_________NO____

Does the child wear hearing aids?

______YES_________NO____

Blood Type: _________________ Date of last Tetanus Shot: _____________

Please indicate anything else that the caregivers should know about your child:

____

____

____

Authorization

Parent/Guardian__________________________________ Date __________
(signature)

Parent/Guardian__________________________________ Date __________
(signature)

Witness: ______________________________________ Date___________

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