YOUTH ACTIVITES MEDICAL INFORMATION FORM

Newton Highlands Congregational Church

54 Lincoln Street, Newton Highlands, MA 02461 U.S.A.

Name _______________________________________ Birthdate ____/______/________grade __________

Name of child's physician(s): ________________________________phone _________________________

________________________________ phone _________________________

Name of child's dentist:______________________________________ phone _________________________

Name of child's orthodontist:_________________________________ phone _________________________

Health plan:____ phone:_________________________

Subscriber name____ ID # __________________________

Please be sure to fill out every line in this section completely!

Permission for medications

I give permission for trained school personnel to dispense the following medications to the child listed above, when indicated, according to Standing Orders of the School Physician:

(initial only those you wish to have dispensed)

Acetaminophen_____ (i.e. Tylenol) Ibuprofen__________ (i.e. Advil, Motrin)

Diphenhydramine ______(i.e. Benadryl)

Parent/Guardian signature______________________________________

Health History (check, giving approximate dates and details, including preferred treatments and medications):

_____Chickenpox____

_____bleeding/clotting disorders____

_____dental/orthodontic problems____

_____Diabetes____

_____frequent ear infections____

_____heart defect/disease____

_____gastrointestinal disorders____

_____operations/serious injuries____

_____orthopedic problems____

_____seizures____

_____skin problems____

_____frequent strep throats/tonsillitis____

_____urinary tract problems____

_____vision/hearing problems____

_____other (note: allergies/asthma are listed below)__________________________ _______

_____hay fever____

_____severe ivy allergy____

_____insect/bee sting allergy____Epipen?_________

_____medication allergies: list medications and reactions________________________________

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_____food allergies: list foods, reactions, treatment_____________________________________

____Epipen?__________

_____asthma____

_____other allergic problems____

<u>for females</u>: has child menstruated? ____ yes ___ no If yes, any problems?__________________________

<u>Current medications:</u> *list **<u>ALL</u>** current medications taken, whether at home or in school*
(or "only when necessary")

Medication	Condition treated	Dosage	How often	Times	

Any specific activities to be encouraged or limited by physician's advice?___________________________

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Signature of parent____ date_______________