Peace Lutheran Church
A Lutheran Congregation in Mission for Christ

Vacation Bible School

8250 Roscoe Rd.
Gulf Shores, AL 36542
251-974-2545
www.PeaceLutheranAL.org

YOUTH EMERGENCY / MEDICAL INFORMATION FORM

Child's Name: (First) _____ **(M.I.)**_____ **(Last)**_____

Home Address: (Street)_____ **(City, State, Zip)**_____

Home Phone: _____ **(Gender)** ___**M**_____**F**___ **(Age)** _____

Birthdate: _____/_____/_____ **(School)** _____

EMERGENCY CONTACT INFORMATION

Parent/Guardian with legal custody to be contacted in case of illness or injury:

Parent/Guardian Name: _____ **Relationship to Child:** _____

Home Address: (Street)_____ **(City, State, Zip)**_____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Second Parent/Guardian or other emergency contact:

Parent/Guardian Name: _____ **Relationship to Child:** _____

Home Address: (Street)_____ **(City, State, Zip)**_____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

MEDICAL INSURANCE INFORMATION

Insurance Company: _____ **Company Phone:** _____

Policy No.: _____ **Group No.:** _____

Subscriber Name: _____ **Birthday:** _____

MEDICAL

Child's Physician: _____ **Physician Phone No.:** _____

Please list all medications being taken by the child:

Name of Medication	Dosage Amount	Times Given	Reason

HEALTH HISTORY

Is the child allergic to any of the following?

Bee Stings	__Y __N	Penicillin	__Y __N	Food	__Y __N	
Dairy Products	__Y __N	Poison Ivy	__Y __N	Other	__Y __N	_____

Is the child subject to any of the following?

Frequent Colds	__Y __N	Sinus Trouble	__Y __N	Kidney Trouble	__Y __N
Convulsions	__Y __N	Constipation	__Y __N	Frequent Sore Throat	__Y __N
Upset Stomach	__Y __N	Fainting	__Y __N		
Ear Trouble	__Y __N				

Has the child had any of the following?

Tuberculosis	__Y __N	ADD/ADHD	__Y __N	Rheumatic Fever	__Y __N
Heart Trouble	__Y __N	Bronchitis	__Y __N	Eating Disorder	__Y __N
Chicken Pox	__Y __N	Asthma	__Y __N		
Diabetes	__Y __N	Hernia	__Y __N		

If you answered "Yes" to any of the above questions, please explain.

Has the child had any serious injuries? Please explain.

Are there any additional details of information regarding the child's health which we need to know?

Special Needs: If your child has a physical, emotional, behavioral, or cognitive special need, please contact the VBS Coordinator at 251-974-2545 to discuss arrangements.

PARENT / GUARDIAN AUTHORIZATION and OVER-THE-COUNTER MEDICATIONS

This health history is correct and accurately reflects the health status of the child mentioned above. The child has permission to participate in all VBS activities except as noted by me on this form. I understand that the information provided here will be shared on a "need-to-know" basis with staff. When necessary or beneficial, the staff has my permission to give the following medications or their equivalent to the child.

___Acetaminophen (Tylenol)	___Ibuprofen (Advil, Motrin)	___Antibiotic Cream
___Cough Drops	___Benadryl (for allergies)	
___Anti-Itch Cream	___Antacid Tabs	

_____ _____
Signature Date

_____ _____
Printed Name Relationship To Child