ST. PAUL LUTHERAN CHURCH
ROOTED AND GROWING

Child/Youth Information Form

Including: Individual data, General Permission, Medical Information, & Release Forms

Program Year 20__ - 20__ *(initial after reviewing in future years)*

1. Name of Child/Youth: ________________________________ DOB: __________

Age: _____ Grade: ____ School: _________________________ cell phone # ___________

2. Name of Child/Youth: ________________________________ DOB: __________

Age: _____ Grade: ____ School: _________________________ cell phone # ___________

3. Name of Child/Youth: ________________________________ DOB: __________

Age: _____ Grade: ____ School: _________________________ cell phone # ___________

4. Name of Child/Youth: ________________________________ DOB: __________

Age: _____ Grade: ____ School: _________________________ cell phone # ___________

Parent/Guardian: ____

Address: ____ _________________________
street town state ZIP

Phone: _________________________

E-mail: ______________________________

Emergency Contact: ____

Relationship to Child: ____________________________

Address: ____________________ ______________________ _______ _______________
Street town state ZIP

Phone: ____________ E-mail: ______________________________

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General Field Trip Permission: I hereby give permission for the youth listed above to attend events as planned by St. Paul Lutheran Church throughout this school year. I understand I will be notified in advance of specific events/activities off-campus and will complete, sign and return specific permission forms.

Signature of parent/guardian:____ Date: ______________________

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Medical Release: I, the undersigned parent/guardian of the youth listed on this form, do hereby give permission for any St. Paul Lutheran Church approved adults to treat said youth for minor injuries and to take him/her to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to the health of the child. I consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care that may be rendered to said minor, under the general specific instructions of ____________________(name of participant's physician) or if unavailable, by an on-call physician at a hospital or clinic. It is understood that this consent is given in advance of any specific diagnosis or treatment and is given to encourage those persons who have temporary custody of my child, in my absence, and said physician to exercise their best judgment as to the requirements of such diagnosis or said medical treatment.
I understand that any and all medical expenses incurred are my responsibility and that there is no medical insurance coverage provided by St. Paul.

Further, as parent/guardian of the named above, I do hereby consent that my child may receive emergency medical treatment from any physician, hospital, or other medical center without the necessity of first notifying me, and do further agree to hold blameless any physician, hospital or other medical center for rendering such services.

Signature of parent/guardian:____ Date: ______________________

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Photo Release:

I give permission for St. Paul Lutheran Church to include my child(ren) in photos taken at St. Paul events for St. Paul communication. I understand that St. Paul will follow guidelines for privacy, which includes no names attached to photos of minors. Photos will be appropriate, and may be removed upon request.

Signature of parent/guardian:____ Date: ______________________

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MEDICAL DATA

A COPY OF THIS FORM WILL BE TAKEN ON EVERY OFF-CAMPUS EVENT THAT THIS YOUTH ATTENDS.

Physician: _____ Phone #: _____

Medical Insurance name and #: _____

Health History:

1. Youth Name: _____

Check those that apply:

____ Asthma
____ Convulsions
____ Diabetes
____ Ear Infections
____ Epilepsy
____ Heart Disease/Defects

____ Allergies (check those that apply)
____ 1. Animals
____ 2. Insect Stings
____ 3. Plants
____ 4. Medicine/Drugs, specify _____
____ Other Allergies, specify _____
____ 5. Hay Fever
____ 6. Pollen
____ 7. Food

Other Health Related Conditions

____ Emotional Issues
____ Fainting
____ Sleep Walking
____ Special Dietary Regimen _____
____ Nosebleeds
____ Motion Sickness
____ Menstrual Cramps
____ Wears Glasses
____ Wears Contact Lenses
____ Hearing Impairment

____ Other (specify) _____

2. Youth Name: _____

Check those that apply:

____ Asthma
____ Convulsions
____ Diabetes
____ Ear Infections
____ Epilepsy
____ Heart Disease/Defects

____ Allergies (check those that apply)
____ 1. Animals
____ 2. Insect Stings
____ 3. Plants
____ 4. Medicine/Drugs, specify _____
____ Other Allergies, specify _____
____ 5. Hay Fever
____ 6. Pollen
____ 7. Food

Other Health Related Conditions

____ Emotional Issues
____ Fainting
____ Sleep Walking
____ Special Dietary Regimen _____
____ Nosebleeds
____ Motion Sickness
____ Menstrual Cramps
____ Wears Glasses
____ Wears Contact Lenses
____ Hearing Impairment

____ Other (specify) _____

3. Youth Name: _____

Check those that apply:

____ Asthma
____ Convulsions
____ Diabetes
____ Ear Infections
____ Epilepsy
____ Heart Disease/Defects

____ Allergies (check those that apply)
____ 1. Animals
____ 2. Insect Stings
____ 3. Plants
____ 4. Medicine/Drugs, specify _____
____ Other Allergies, specify _____
____ 5. Hay Fever
____ 6. Pollen
____ 7. Food

Other Health Related Conditions

____ Emotional Issues
____ Fainting
____ Sleep Walking
____ Nosebleeds
____ Motion Sickness
____ Menstrual Cramps
____ Wears Glasses
____ Wears Contact Lenses
____ Hearing Impairment

____ Special Dietary Regimen _____

____ Other (specify) _____

4. Youth Name: _____

Check those that apply:

____ Asthma
____ Convulsions
____ Diabetes
____ Ear Infections
____ Epilepsy
____ Heart Disease/Defects

____ Allergies (check those that apply)
____ 1. Animals
____ 2. Insect Stings
____ 3. Plants
____ 4. Medicine/Drugs, specify _____
____ Other Allergies, specify _____
____ 5. Hay Fever
____ 6. Pollen
____ 7. Food

Other Health Related Conditions

____ Emotional Issues
____ Fainting
____ Sleep Walking
____ Nosebleeds
____ Motion Sickness
____ Menstrual Cramps
____ Wears Glasses
____ Wears Contact Lenses
____ Hearing Impairment

____ Special Dietary Regimen _____

____ Other (specify) _____