



Child's Name  
(Last) (First) (MI) (Age)

**Contact Information**

Father \_\_\_\_\_ Mother \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Father's Cell Phone \_\_\_\_\_ Mother's Cell Phone \_\_\_\_\_

Friend or Relative \_\_\_\_\_ Phone \_\_\_\_\_

Child's Doctor \_\_\_\_\_ Doctor's Phone \_\_\_\_\_

Parents are \_\_\_\_\_ married \_\_\_\_\_ separated \_\_\_\_\_ divorced \_\_\_\_\_ other

Custodial parent is \_\_\_\_\_

Child lives at home with \_\_\_\_\_

Cell Phone

**Allergies**

Drugs \_\_\_\_\_

Foods \_\_\_\_\_

Latex or other allergies \_\_\_\_\_

**Vaccines**

Tetanus (date) \_\_\_\_\_ Hepatitis B (date) \_\_\_\_\_

**Medications** (dosage, frequency) \_\_\_\_\_

**Hospitalizations / Surgeries** (list) \_\_\_\_\_

Birth Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Last

Middle

**Medications**

Place a check by any of these over the counter medications your child may receive. Note – These medications will be given by an adult chaperon. We prefer that an adult be notified if your child is traveling with any medicines (over the counter, prescription, etc.).

First

Tylenol (acetaminophen)

Mylanta / Maalox / Tums / Roloids (antacid)

Advil / Motrin (ibuprofen)

Zantac (ranitidine)

Benadryl (diphenhydramine)

Other \_\_\_\_\_

Nickname

Imodium (loperamide hcl)

\_\_\_\_\_

Sudafed (phenylephrine)

\_\_\_\_\_

Pepto Bismol (bismuth subsalicylate)



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**Medical History**

Additional information may be typed and attached

**Eyes**

- Contacts
- Glasses

**Ear, Nose, and Throat**

- TMJ
- Other \_\_\_\_\_

**Heart**

- Heart Murmur
- Mitral valve prolapse
- Family history of sudden death
- Other \_\_\_\_\_

**Lung**

- Asthma (list medications)
- Other \_\_\_\_\_

**Gastrointestinal**

- Reflux
- Irritable Bowel Syndrome
- Other \_\_\_\_\_

**Neurological**

- Seizures
- Fainting Spells
- ADD / ADHD
- Eating Disorders
- Other \_\_\_\_\_

**Orthopedic**

- Chronic bone / joint problems
- Previously broken bones (list as necessary)
- Other \_\_\_\_\_

**Hematological**

- Anemia
- Free Bleeding
- ITP
- Leukemia / Cancer
- Other \_\_\_\_\_

**Endocrine**

- Diabetes (How long? List insulin type, dose, frequency) \_\_\_\_\_ years
- Thyroid
- Other \_\_\_\_\_

**Kidney**

- Kidney problems

Other Health Problems Not Listed \_\_\_\_\_

\_\_\_\_\_



**Insurance**

(If possible, please include a copy of card)

Name of Subscriber \_\_\_\_\_

Company \_\_\_\_\_

ID Number \_\_\_\_\_

Group number \_\_\_\_\_

Subscriber \_\_\_\_\_

Subscriber birth date \_\_\_\_\_

I understand that this information will be released to Matthew Savage and/or other agents of Southern Hills Church of Christ. I \_\_\_\_\_ authorize Matthew Savage or other agents of Southern Hills Church of Christ to seek emergent or non-emergent medical care on behalf of my child \_\_\_\_\_ as deemed necessary. I also allow them to receive information regarding the treatment, care and condition of my child.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature