Buncombe Street Methodist Church - 200 Buncombe Street - Greenville, SC 29601

MINOR HEALTH RELEASE 2-PAGE FORM

IDENTIFICATION

Name_____ Date of Birth _____ Age _____ Sex _____

Name of Parent or Guardian _____ Telephone _____

Home Address _____ City _____ State _____ Zip _____

If parent/guardian named above is not available in the event of an emergency, notify:

Name_____ Relationship _____ Telephone _____

Name_____ Relationship _____ Telephone _____

Name of Personal Physician_____ Telephone _____

Personal health/accident insurance carrier _____ Policy No. _____

HEALTH HISTORY

The following information must be filled in by the parent/guardian. The intent of this information is to provide health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to personnel upon participant's arrival in activity. Provide complete information so that Buncombe Street can be aware of your child's needs.

GENERAL QUESTIONS (Explain "yes" answers below)

Has/does the participant:

1. Have chronic or recurring illness/condition?.....Y ☐ N ☐
2. Ever been hospitalized?.....Y ☐ N ☐
3. Have frequent headaches?.....Y ☐ N ☐
4. Ever had a head injury?.....Y ☐ N ☐
5. Ever had frequent ear infections?.....Y ☐ N ☐
6. Ever passed out during or after exercise?.....Y ☐ N ☐
7. Ever been dizzy during or after exercise?.....Y ☐ N ☐
8. Ever had chest pain during or after exercise?.....Y ☐ N ☐
9. Ever had seizures?.....Y ☐ N ☐
10. Have asthma?.....Y ☐ N ☐
11. Have a history of bedwetting?.....Y ☐ N ☐
12. Has your child been diagnosed with ADHD?.....Y ☐ N ☐
13. Ever had high blood pressure?.....Y ☐ N ☐
14. Ever been diagnosed with a heart murmur?.....Y ☐ N ☐
15. Ever had back problems?.....Y ☐ N ☐
16. Wear glasses, contacts or protective eyewear?.....Y ☐ N ☐
17. Have an orthodontic appliance being brought to camp?.....Y ☐ N ☐
18. Have any skin problems? (itching,rash,acne,etc.).....Y ☐ N ☐
19. Have diabetes?.....Y ☐ N ☐
20. Ever had an eating disorder?.....Y ☐ N ☐
21. Have emotional difficulties for which professional help was sought?..Y ☐ N ☐
22. Ever had trouble with homesickness?.....Y ☐ N ☐

Height: _____ Weight: _____

Please explain any "yes" answers, noting the number of the questions.

Use the space below to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the leaders should be aware.

Child's Name _____

MEDICATIONS BEING TAKEN (IF GOING ON OVERNIGHT TRIP)*

*Please list ALL medications (including over the counter or non-prescription drugs) taken routinely. Bring only medicines to that require prescriptions. We will administer the non-prescription medications to children upon their request or instruction from parent/guardian. Bring prescription medicines in the original packaging bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

❑ This person takes NO medications on a routine basis.

❑ This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking: _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking: _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking: _____

Med #4 _____ Dosage _____ Specific times taken each day _____

Reason for taking: _____

Please attach an additional page if additional medications are taken.

My child is permitted to take Tylenol for headache: Yes ☐ No ☐ Other: _____

My child is permitted to take _____ for fever.

Is your child subject to motion sickness?: Yes ☐ No ☐ If yes, what medicine may your child take? _____

Does your child have allergies to any of the following?

Medicines: .....Yes ☐ N ☐ _____

Plants: .....Yes ☐ N ☐ _____

Insects (bees,spiders): .....Yes ☐ N ☐ _____

Food:.....Yes ☐ N ☐ _____

Other: .....Yes ☐ N ☐ _____

SPECIAL DIET If your child requires a doctor prescribed diet, please indicate diet and reason below. Vegetarian.

(Please attach sample menu or special food list.)

IMMUNIZATIONS: (Give date of last inoculation.)

Tetanus toxoid _____ Measles _____ Polio _____

Diphtheria _____ Mumps _____

Pertussis _____ Rubella _____

PARENT/GUARDIAN AUTHORIZATION: This health history is correct and complete as far as I know. I agree to notify Buncombe Street if any change occurs in my child's medical condition before arriving at event. The person herein described has permission to engage in all planned activities except as noted above. I hereby give permission to the program leaders to provide routine health care, administer prescribed medications, and seek emergency medical treatment. I give permission to the camp to arrange necessary related transportation for my child. I agree to the release of any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program leaders to secure and administer medical or surgical treatment under local and general anesthesia, including hospitalization for the person named above. I hereby waive and release Buncombe Street United Methodist Church and its staff from any and all liability for any injury or illness incurred at camp.

DISCLAIMER LANGUAGE

You consent that any photos, video or sound recordings of your (your child's) activities or works from participating in Buncombe Street Methodist Church (BSMC) activities are the sole property of BSMC and may be used by us for any legal purpose without payment to you. Such uses may involve the inclusion of such photos, video or sound recordings in any materials (including our website, publications, promotions, advertisements, or other materials), whether as originally taken or as modified by us.

Parent/Guardian Name _____

Date _____

☐ Parent/Guardian - check this box and confirm that the information is correct.

When complete, return the form to the church staff member. Thank you.