



Youth Participant/Group Health Form



Participant's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_

Name of Parent / Guardian : \_\_\_\_\_

Address: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Night Phone: \_\_\_\_\_

Doctor's Name \_\_\_\_\_

\_\_\_\_\_  
Address Zip Phone

Health Insurance: \_\_\_\_\_ Policy or Plan # \_\_\_\_\_

Participant's Medical # (if applicable) \_\_\_\_\_

Name of emergency contact: \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_  
Address Zip Day Phone Eve Phone

Does this participant have any physical or emotional conditions of which the youth group advisor should be aware?

Restrictions on activities: \_\_\_\_\_

Regularly prescribed medications: \_\_\_\_\_

Date of most recent tetanus booster? \_\_\_\_\_

Allergies to drugs? Allergies to food or special diet? \_\_\_\_\_ Allergies, other? \_\_\_\_\_

**Parent's Authorization:**

This health history is correct as far as I know. The person herein described has my permission to engage in all prescribed activities except as noted above. The following authorization empowers the staff of FIAC, Inc., Youth Group to take whatever steps they deem necessary to insure the wellbeing of your child should a medical emergency occur during a youth group meeting/activity. Every attempt will be made to contact the parent or emergency contact provided.

I, \_\_\_\_\_ do hereby authorize FIAC, Inc. Youth Group to take necessary emergency measures in the treatment of my son/daughter \_\_\_\_\_ if needed, My son/daughter is in good physical health and does not have any disabilities which may be aggravated except as noted on this form. I release FIAC, Inc., and its agents from all responsibilities other than supervised, scheduled activities. In the event that I cannot be reached in an emergency, I hereby authorize the physician selected by FIAC, Inc. to hospitalize, secure proper treatment for, and order injections; anesthesia and surgery for my child named above.

\_\_\_\_\_  
Signature of Parent / Guardian Date