

Damascus Community Church
14251 SE Rust Way Damascus Oregon 97009 503.658.3179

Health Form

(Please Print)

Name of Student _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Sex _____ Height _____

Weight _____ Social Security # _____

Emergency Contact Person:

Parent/Guardian Name _____

Address (if different than above) _____

City _____ State _____ Zip _____

Work Phone (____) _____

Cell Phone (____) _____

Alternate Contact Person: (use someone near the primary contact)

Name _____

Address: _____

City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while your child is at the activity.

Do you have health insurance? _____ Yes _____ No

Name of Insurance Company _____

Policy Number _____ Group Number _____

In whose name is the insurance? _____

Insurance Company pre-authorization phone number: _____

Family Doctor _____ City _____

Phone Number (____) _____

Damascus Community Church

14251 SE Rust Way Damascus Oregon 97009 503.658.3179

If your child should require medical attention for injuries received or illnesses contracted prior to the activity, please send us the necessary information to give him/her proper medical care during his/her time with the youth ministry activity.

Health History:

Pre-existing or present medical conditions:

Name and dosage of any medications that must be taken:

Any allergies ? _____
to medications? _____

- | | |
|---|---|
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Epilepsy/Nervous Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Stomach Upsets |
| <input type="checkbox"/> Physical Handicaps | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Any Major Illnesses during the past year ? | |

If any of the above is checked, please give details (example; include normal treatment of allergic reactions)

Date of last Tetanus Shot _____ Contact Lenses? _____

Any swimming restrictions Yes No

What are they?

Any activity restrictions? Yes No

What are they?
