

Roselle United Methodist Youth Group Health Card

Name _____ Birth Date _____ Sex _____

Parents/Guardian _____

Address _____ City _____ State _____ Zip _____

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

Date of TB: ___ / ___ / ___ Tetanus: ___ / ___ / ___ Any Red Cross Training? Y / N Type _____

List any of the following, including dates – Operations, Serious Injury, Disability Or Chronic / Recurring Illness:

Any activities to be restricted? If yes, list. _____

Any Physical / Emotional symptoms to watch for?

List any allergies (include medicines or food)

Dietary Modification: _____

Current Medication and Dosage: _____

Name of Physician: _____ Physician's Phone #: (____) _____

Insurance Carrier: _____ Insurance Carrier Phone #: (____) _____

Policy or Group #: _____ Does Carrier Require Prior Notification? YES / NO

Emergency Authorization

I give permission to and will hold harmless Roselle United Methodist Church and the authorized representatives of RUMC to act in my absence in an emergency. I hereby give permission to the physician available to provide any proper medical care deemed necessary for the person named above.

Signature of parent/guardian _____ Date ___ / ___ / ___