

To Be Brought to Florida Annual Conference by Delegate
HEALTH RECORD

To Be Completed by Parent or Guardian and Notarized

Name: _____ Social Security # _____

Male Female Date of Birth ____/____/____ Age _____

Has there been a recent exposure to a contagious disease? no yes

If so, which one and when? chicken pox _____; measles _____; mumps _____; other: _____

Are there any allergies or reactions to: medications what? _____

aspirin aspirin substitute insect bites or stings pollen poison ivy or oak other _____

Any history of: Congenital deformity or major disability? What? _____

Chronic infection of nose, throat, ears or sinus Asthma or lung disease Heart disease Diabetes

Hernia Tendency to faint Convulsive seizures/epilepsy Sleep walking Bed wetting Athlete's foot

Has girl menstruated? yes no Have irregular or painful menses

Any recent operations, serious injuries or illness? _____

Other _____

List present medications: _____

What restrictions, if any, should be observed for your child? _____

Tetanus inoculation date ____/____/____. It is recommended to have series of DPT, DT or tetanus booster in past ten years.

MEDICAL CONSENT

In the event of any emergency illness or accident, a Florida Annual Conference representative will contact parents/guardians at the earliest possible moment. However, as contact cannot always be made immediately due to "no one at home," busy circuits, etc. we need emergency permission signed and notarized.

In the event that my child, _____ suffers any illness or accident, requiring emergency hospitalization, medication, or surgery while in any part of the Florida Annual Conference in Lakeland, Florida, I hereby give my permission for any necessary hospitalization, medication, or surgery on recommendation of the attending physician after consulting the camp authorities, understanding that the Florida Annual Conference representative will contact me at the earliest possible moment.

I further authorize a routine visit to the physician should my child contract an illness needing medical attention and I agree to reimburse the Program if this illness is not covered under their accident insurance policy. I agree not to hold the camp or organization liable for injuries my child may sustain during the Florida Annual Conference.

SIGNATURE of Parent/Guardian

PRINTED Name of Parent/Guardian

Home Phone Number: (____) _____

Work Phone Number(____) _____

Ibuprofen may be given if needed yes no

Calamine/caladryl may be applied if needed yes no

Tylenol may be given if needed yes no

Topical antibiotic (Neosporin, bacitracin, etc)yes no

IF PARENT OR GUARDIAN CAN NOT BE REACHED IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name & Relationship: _____

Day Phone: (____) _____

Evening Phone: (____) _____

TO BE COMPLETED BY A NOTARY PUBLIC:

State of Florida: County of _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by (print name)

_____ who is personally known to me or has produced (type of identification) .

_____ as identification and did not take an oath.

Notary Public (signature): _____ Notary Public (printed): _____

My Commission expires: _____ My Commission number is: _____

(Notary Seal)