

Last Name _____ First Name _____ Gender _____

Health Insurance Carrier _____ Birth Date ____/____/____ Age _____

Health Insurance Group/Policy Number _____ Grade (As of May 2019) _____

HEALTH HISTORY		
CHRONIC CONCERNS ☐ Seizures/Convulsions ☐ Mononucleosis ☐ Fainting/Dizzy Spells ☐ Head Injury ☐ Sleepwalking ☐ Frequent Headaches ☐ Diabetes ☐ Heart Disease/Defect ☐ Asthma ☐ High Blood Pressure ☐ Frequent Ear Infections ☐ Cancer ☐ Bleeding/Clotting Disorder ☐ Menstrual Problems ☐ Kidney Disease ☐ Developmental Delays ☐ Learning Disability ☐ Other Please explain each item checked: _____ _____ _____	MENTAL/EMOTIONAL HEALTH ☐ ADD/ADHD ☐ Anxiety ☐ Depression ☐ Bipolar Disorder ☐ Eating Disorder ☐ Other Please explain each item checked and share any other information that will help Augustana care for your child: _____ _____ _____	DIETARY CONCERNS ☐ Vegetarian ☐ Vegan ☐ Lactose Free ☐ Gluten Free ☐ Nut Free ☐ Other Please explain each item checked and share any other information that will help Augustana care for your child: _____ _____ _____
ALLERGIES ☐ No Known Allergies ☐ Insects ☐ Foods ☐ Medications ☐ Other Please describe allergen, reaction, and treatment. Attach more information as needed. If participant carries an EpiPen, please complete the EpiPen Action Plan. _____ _____ _____		

MEDICATIONS	Please complete the form with all medications (prescription, over-the-counter, vitamins) that will be brought to Augustana's event. Ensure that dosages and instructions are accurate.
MEDICATION #1	
Medication Name (exact name) _____ Dosage (mg/ml & tab/capsule) _____ Administration Time: ☐ As Needed ☐ AM ☐ PM ☐ Other _____ ☐ Taken with food Reason for Giving _____	
MEDICATION #2	
Medication Name (exact name) _____ Dosage (mg/ml & tab/capsule) _____ Administration Time: ☐ As Needed ☐ AM ☐ PM ☐ Other _____ ☐ Taken with food Reason for Giving _____	
MEDICATION #3	
Medication Name (exact name) _____ Dosage (mg/ml & tab/capsule) _____ Administration Time: ☐ As Needed ☐ AM ☐ PM ☐ Other _____ ☐ Taken with food Reason for Giving _____	
MEDICATION #4	
Medication Name (exact name) _____ Dosage (mg/ml & tab/capsule) _____ Administration Time: ☐ As Needed ☐ AM ☐ PM ☐ Other _____ ☐ Taken with food Reason for Giving _____	

STOCK OVER-THE-COUNTER MEDICATIONS

The following medications are stocked. These medications are administered by our volunteer adult leader.

Please cross off any medications that **SHOULD NOT BE GIVEN**.

Acetaminophen/Tylenol	Antacids/Tums	BZK Wipes	Diphen/Benadryl	Imodium
Alcohol Wipes	Aquaphor	Calamine Lotion	Emergen-C	Insta-Glucose
Aloe Vera	Antibiotic Ointment	Campho-Phenique	Gold Bond Powder	Saline Eye Wash
Anbesol	BioFreeze	Cough Drops	Hydrocortisone CR	Sunscreen
Ammonia Inhalants	Bug Spray	Cough Syrup	Ibuprofen/Advil	Psuedoval/Sudafed

Required vaccines	Each immunization date MM/DD/YY						Titer date
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
DT Diphtheria, Tetanus (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib Haemophilus influenzae type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							
Varicella date of disease							
Varicella positive screen date							

Recommended vaccines	Each Immunization date MM/DD/YY						Please attach Immunization Exemptions, Asthma Care Plans, Epi-Pen Action Plans to this form, if needed.
HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

PARENT/GUARDIAN RELEASE

I approve the over-the-counter medications above for use as needed by the participant. I have crossed off medications that are not approved for use by said participant.

I hereby request and give my permission to the Augustana Lutheran Church health care worker to administer medication to the participant identified above. I understand that all medications must be provided in the original pharmacy labeled container. I understand my child assumes responsibility for going to the health clinic at specified times for medications.

I hereby give my permission to Augustana Lutheran Church to give care to the participant identified above in case of illness or injury and understand Augustana Lutheran Church will attempt to contact me in such event. Augustana Lutheran Church and its staff have authorization to obtain medical treatment and procedures for the participant as may be appropriate in emergency circumstances, including treatment by physicians, hospital and clinic personnel, and other appropriate healthcare providers.

Signature of Parent or Guardian _____ Date _____