Augustana
LUTHERAN CHURCH

Participant Health Form 2020

Last Name _____ First Name _____ Gender _____

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

Health Insurance Group/Policy Number _____ Grade (As of May 2020) _____

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.**

Acetampinophen/Tylenol	Antacids/Tums	BZK Wipes	Diphen/Benadryl	Immodium
Alcohol Wipes	Aquaphor	Calamine Lotion	Emergen-C	Insta-Glucose
Aloe Vera	Antiobiotic 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 (pediatricl							
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					
HPV Human Papillomavirus						Please attach Immunization Exemptions, Asthma Care Plans, Epi-Pen Action Plans to this form, if needed.
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 _____