

Lake Washington United Methodist Church  
Kirkland, Washington 98033  
**Emergency Information Sheet 2009-2010**

Note: This information sheet is to be filled out by the parents or legal guardian of each Youth. It will be taken on each activity in which the Youth participates. Should an emergency arise, the information that you have listed will be used in any medical treatment that he/she might receive.

**MEDICAL CARE**

NAME OF YOUTH \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

In case of medical emergency, I understand that every effort will be made to contact me and the emergency contact person. In the event neither of us can be reached, I hereby authorize and request the adult counselor(s) to secure emergency medical and/or hospital care for \_\_\_\_\_.

**(Name of Youth)**

I hereby give permission to the physician selected by the counselor(s) to hospitalize, secure proper treatment for, and/or to order injection, anesthesia, or surgery for the above-named Youth.

I accept full financial responsibility for any medical services required, including prescription and non-prescription drugs and other supplies, on behalf of my child.

**DATE** \_\_\_\_\_ **SIGNATURE OF PARENT/GUARDIAN** \_\_\_\_\_

Parents/Guardian Name \_\_\_\_\_

Home Phone \_\_\_\_\_

Mom's Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Dad's Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**HEALTH QUESTIONNAIRE-All information is strictly confidential**

NAME OF YOUTH \_\_\_\_\_ a physical examination is recommended if there has been none within the past year.

Currently healthy? \_\_\_\_\_ if no, please indicate health problem(s): \_\_\_\_\_

Immunization/latest Booster Dates: D.P.T. \_\_\_\_\_ Tetanus \_\_\_\_\_ Polio \_\_\_\_\_

Smallpox \_\_\_\_\_ Other: \_\_\_\_\_

Allergies, Conditions (Y/N): Hayfever \_\_\_ Asthma \_\_\_ Convulsion \_\_\_ Fainting \_\_\_

Poison Ivy \_\_\_ Penicillin \_\_\_ Sulfa \_\_\_ Bee Sting \_\_\_

Other \_\_\_ (Describe): \_\_\_\_\_

If Yes to any of the above, please indicate treatment, past or present, and preventative and emergency measures which should be taken: \_\_\_\_\_

Medications: Please list any medications which are being taken at present, dosages, times, and other pertinent information: \_\_\_\_\_

Other Information: \_\_\_\_\_

**DATE** \_\_\_\_\_ **SIGNATURE OF PARENT/GUARDIAN** \_\_\_\_\_