# ST. PAUL'S HEALTH HISTORY FORM

**To be completed by parent/guardian of those under 18 years. 12N 6TH ST. WILMINGTON, NC 28401**

Name _____ Birth date _____ Sex ___ M ___ F
Last First Initial

**Parent or Guardian** _____ Youth's Grade _____ Youth's Age ____
Name

Home Address _____
Street, Road or Box City State Zip

Phone _____ Cell Phone _____ email address_____
Area/number Area/number

**Second Parent / Guardian, or Emergency Contact** _____
Name

Home Address _____ Phone _____
Street, Road or Box City State Zip Area/number

Phone _____ Business Phone _____ Cell Phone _____
Area/number Area/number Area/number

**If above are not available in an emergency, contact**: _____
Name

Address _____Relationship _____
Street, Road or Box City State Zip

Phone _____ Business Phone _____ Cell Phone _____
Area/number Area/number Area/number

**Allergies:** (please check)
_____ Drug Allergies (Specify)
_____
_____
_____ Insect Stings
_____ Hay Fever
_____ Other (Specify)_____
_____

**Health History:**
_____ Frequent Ear Infections
_____ Heart Defect/Disease
_____ Convulsions
_____ Bleeding/Clotting Disorder
_____ Mononucleosis
_____ Diabetes (year) _____
_____ Chicken Pox
_____ Hypertension
_____ Measles
_____ Mumps
_____ German Measles
_____ Psychiatric Treatment
_____ Asthma

**Medications:** (Explain dosage and reason on reverse side)
_____
_____

**Immunization Record:**
Date of last Tetanus _____ , DPT _____ , Polio _____, MMR _____

**Dietary Restrictions:** _____
**Activity Restrictions:** _____
Chronic illness, operations, or serious injury: (use reverse side if necessary)

**For females:** Has this person menstruated? _____ If not, has she been told about it? _____ If so, is her menstrual history normal? _____.

***PLEASE USE THE REVERSE SIDE TO LIST OTHER INFORMATION WHICH MAY BE HELPFUL TO US.***

⇨ ***Local Urgent Care providers require a copy of your insurance card and can refuse care without a copy.***

**Insurance:** Health Insurance Co. _____
Policy or ID # _____ Group Plan ID #_____
Name of Insured _____Ins Co. Ph. #_____
Where insured is employed _____
Address for claims _____
_____

**Family Physician** _____ Phone _____

**Emergency Authorization**: I hereby give permission to the chaperones of St. Paul's to order x-rays, routine tests and treatment for me/my child and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or supply for me/my child as named above. This form may be photocopied for use out of camp.

**Check here ☐ if you do NOT give permission for ST. PAUL'S to photograph your child for Youth Group or Family ministry purposes (brochures, etc.).**

**Signature of Parent/Guardian** _____

Witness: _____ Date _____

This form is designed to help us provide a safe and enjoyable experience. Please fill it out and mail or deliver it to Emily Clamser. **Children cannot attend any trip, camp, or overnight function without a signed health history.** Thank you.