Georgia Cumberland Conference Health History Form

Club Name: Collegedale Pathfinders		Director Name: Dianna Knapp	
Child's Legal Name:			Preferred Name:
Age	Birthdate_____/_____/_____ Month/ Day/ Year		Gender: ☐ Female ☐ Male
Mailing Address			
City	State		Zip
Who has legal custody of child? ☐ Both Parents ☐ Mother ☐ Father ☐ Other_____			
Parent/Guardian with legal custody to be the primary contact in case of illness or injury:			
Name:			Relation to Child:
Primary Phone: ( )		Alternate Phone: ( )	
2nd parent/guardian or other emergency contact (optional):			
Name:			Relation to Child:
Primary Phone: ( )		Alternate Phone: ( )	
Additional contact in event parent/guardian(s) can not be reached (optional):			
Name (s):			Relation to Child:
Primary Phone: ( )		Alternate Phone: ( )	

Health Care Providers

Physician	City	Office Phone: ( )
Dentist	City	Office Phone: ( )
Orthodonist	City	Office Phone: ( )

Child Health Insurance Information

This child is covered by family health insurance? ☐ Yes ☐ No		Policy Holder
Insurance Company	Phone: ( )	Holder's Birthdate: _____/_____/_____ Month/ Day/ Year
Employer	Policy Number:	Group Number:

Immunizations

Are all your child's immunizations, required for school, up-to-date? ☐ Yes ☐ No

Tetanus Status: Month_____ Year_____ (The month and year of the most recent Tetanus shot is **required**)

If doctor advises, may Tetanus Immunization be administered? ☐ Yes ☐ No

If your child has not been fully immunized, please sign the following statement:

☐ *I understand and accept the risks to my child from not being fully immunized.*

_____

*Legal Parent/Guardian's Signature Date

General Health History: Check "Yes" or "No" if the child has or had a history of the following:

1. Asthma/wheezing	☐ Yes ☐ No	10. Seizure Disorder	☐ Yes ☐ No		
2. Diabetes	☐ Yes ☐ No	11. Fainting or dizziness	☐ Yes ☐ No		
3. Back or joint problems	☐ Yes ☐ No	12. Heart Condition	☐ Yes ☐ No		
4. Headaches	☐ Yes ☐ No	13. Stomach Upsets	☐ Yes ☐ No		
5 Diarrhea	☐ Yes ☐ No	14. Sprain, Dislocation etc	☐ Yes ☐ No		
6. Constipation	☐ Yes ☐ No	15. Sleep problems or Sleepwalking	☐ Yes ☐ No		
7. Sinusitis	☐ Yes ☐ No	16. Recurrent/chronic illnesses.	☐ Yes ☐ No		
8. Ear Infections/Ear Tubes (circle)	☐ Yes ☐ No	17. Communicable (Infectious) Disease	☐ Yes ☐ No		
9. Frequent Sore Throats	☐ Yes ☐ No	18. Eye Glasses/Contacts (circle)	☐ Yes ☐ No		

Other (not listed)_____

List any hospitalizations, Surgeries or Broken Bones:

Year	Hospitalization/Surgery/Broken Bones	Explanation

Georgia Cumberland Conference Health History Form (continued)

Club Name: Collegedale Pathfinders	Director Name: Dianna Knapp
Child's Legal Name:	Birthdate: _____/_____/_____ Month/ Day/ Year

Allergies:
☐ No known allergies
☐ This child is allergic to: ☐ Food(s) ☐ Medicine(s) ☐ Environment (insect, pollen, etc.) ☐ Other

List all Allergies:	Reaction

Medications/Vitamins/Natural Remedies Child Needs (to be provided by Parent/Guardian):
☐ This child will **not** take any daily medications while attending events.
☐ This child will need to take the following medications while attending events:
List medications, vitamins, etc. to be taken: (Any psychotropic drugs must be at the therapeutic level – 3 months minimum use.)

Medication Name	Dose	Frequency	Reason	What happens if dose is missed?
		☐ Breakfast ☐ Dinner ☐ Other ☐ Lunch ☐ Bedtime _____		
		☐ Breakfast ☐ Dinner ☐ Other ☐ Lunch ☐ Bedtime _____		
		☐ Breakfast ☐ Dinner ☐ Other ☐ Lunch ☐ Bedtime _____		

*__All medications, vitamins or natural remedies (prescription and/or over-the-counter) must be brought in the original bottle and turned into the Director by the parent/guardian.__

OTC Medications: Please mark Yes if you approve or No if you do not approve for the below over the counter medicines to given to your child in the event of a minor illness by the designated staff.

Yes	No		Yes	No	
☐	☐	Acetaminophen (Tylenol)	☐	☐	Diphenhydramine antihistamine/allergy medicine (Benadryl)
☐	☐	Ibuprofen (Advil, Motrin)	☐	☐	Antihistamine/allergy medicine (Zyrtec/Claritin)
☐	☐	Throat lozenges for sore throats	☐	☐	Pseudoephedrine decongestant (Sudafed)
☐	☐	Sore throat spray (Chloraseptic)	☐	☐	Phenylephrine decongestant (Sudafed PE)
☐	☐	Calamine lotion	☐	☐	Guaifenesin cough syrup
☐	☐	Antibiotic cream	☐	☐	Dextromethorphan cough syrup
☐	☐	Aloe	☐	☐	Bismuth subsalicylate for diarrhea (Immodium, Pepto-Bismol)
☐	☐	Ointment for rash (Hydrocortisone)	☐	☐	Upset stomach/nausea/indigestion (Tums, etc.)
☐	☐	Laxative for constipation	☐	☐	Other _____

If there are any restrictions on Activities or Diet please note here:
_____
_____
_____

Parent Authorization for Treatment – *required for those under 18 years of age.*

This health history is correct and accurately reflects the health status of the child as far as I am aware. The child will turn in all medications to the Director and will take any and all prescribed medications sent by the parent/guardian. I give permission to the designated staff to give over-the-counter medications as indicated above. If I cannot be reached in an emergency, I give permission to the physician selected by the designated staff to examine, order any x-rays or routine tests , to hospitalize, secure proper treatment, order injections, anesthetic, medical and/or surgical treatment to said minor. I understand the information on this form will be shared on a "need to know" basis with the staff. In addition, the staff have permission to obtain a copy of my child's medical record from providers who treat my child and these providers may talk to the attending staff about the child's health status. I hereby authorize any hospital or physician, or any other person who has attended or examined said minor to furnish the insurance company or its representative any and all information with respect to any illness, injury, medical history, consultation, prescriptions, or treatment and copies of all hospital or medical records in regards to receiving payment for their services. I accept the conditions stated, including the release of the Georgia Cumberland Conference management from liability in case of serious injury or death. I hereby give my consent for said child to participate in all activities. This consent shall remain in continuous effect until revoked in writing. A photo copy of this form shall be as effective and valid as the original.

_____

***Parent/Guardian's Signature** **Date** **Relation to Child**

*This form is to be completed and signed by the primary parent/guardian whose name appears on the front page.

Please Note: Health insurance remains the family's responsibility to provide.