First Lutheran Church
402 S Court Street • Fergus Falls, MN 56537
218-739-3348
www.firstlutheranchurchff.org

# MINOR'S HEALTH FORM

Please complete the following health form. Minors **MUST** have a **completed** health form to participate in events.

**Child's Name**: ______________________________________________

Last First Middle Initial

Mailing Address: ______________________________________________

City, State, ZIP: ______________________________________________

Child's Cell Phone Number (for 7th-12th graders only) ______________________

Nickname: ____________________ Age: ________ Birth Date: ____________ Grade________

**Parent/Guardian**: ______________________ Day Phone Number: ______________

Relationship: __________ Evening Phone Number: __________ Cell Phone Number: __________

Mailing Address (if different than above):______________________________

**Parent/Guardian**: ______________________ Day Phone Number: ______________

Relationship: __________ Evening Phone Number: __________ Cell Phone Number: __________

Mailing Address (if different than above):______________________________

**Insurance/Billing Information:** In the event of an accident or injury requiring medical attention, your personal insurance will be considered **PRIMARY CARRIER**.

Company Name: ______________ Policy Number: ______________________

**Health History:** First Lutheran Church uses this information to…

1) Provide health care with an informed background about your child
2) Educate workers/volunteers about their respective student's needs

**Allergies/Food Restrictions:** Check those which apply to this child.

- □ This child has no known allergies.
- □ This child has an allergy to the following food(s), medication(s), and/or substance(s): ______________

______________________________________________

Do any of these allergies this cause anaphylaxis? □ Yes □ No

Describe the reaction(s) and what can be done for management (attach any additional information if needed):

______________________________________________

______________________________________________

**General Health History:** This child has had: ___________________________________________

☐ This child has hearing within normal ranges.

☐ This child has vision within normal range.

This child is free from illness, injury, or surgery which would affect participation…. ☐ Yes ☐ No

**Chronic Health Concerns:** Check all that pertains to this child and provide information that would aid in providing supportive health care and a supportive environment.

☐ This child has no chronic concerns and is capable of full participation.

☐ This child has the following chronic concern(s):

☐ Asthma ☐ Diabetes ☐ Heart Defect/Disease ☐ Seizure Disorder

☐ Hypertension ☐ Frequent Colds ☐ Frequent Ear Infections ☐ Bleeding/Clotting Disorder

☐ Other (please describe) ___________________________________________

Additional Information about checked item(s): ___________________________________________

**Mental/Emotional Health Concerns:** Check "Yes" or "No" for each statement.

This child has an emotional health concern ........................................☐ Yes ☐ No

This child has a learning disability ........................................☐ Yes ☐ No

This child has been diagnosed with Attention Deficit Disorder (ADD or ADHD)........................................ ☐ Yes ☐ No

*If "yes" was answered to anything in this section, please attach a statement if any special considerations should be taken*

**Medication:** All medications must be given by the minor's parent(s)/guardian(s) except in the case of asthma or an allergic reaction.

Please check if your minor has the following:

☐ inhaler ☐ EpiPen

**Immunization:** Please note month and year of the shots or the most recent booster.

DTP: Diphtheria, Tetanus, Pertussis ________________ Td: Tetanus Booster ___________________________

MMR: Measles, Mumps, Rubella ________________ Others: ___________________________

**Doctor/Dentist Contact Information:**

Name of Child's Physician___________________________________ Phone ______________________

Dentist___________________________________ Phone______________________

**In Case of Illness**

My child will stay home from church activities if he/she has any of the following symptoms:

- Fever over 100.5 degrees within the last 24 hours;
- Diarrhea or vomiting within the last 24 hours;
- Eye or skin infections; and/or
- Other symptoms of communicable or infectious disease.