Last Name: _____

Date: _____

General Information

This form is valid for 12 months *and applies to all Church of the Apostles programs for children and youth up to age 18 (hereafter referred to as "children"). To remain valid, any changes to the information included on this form must be provided to Church of the Apostles.*

Name of Child: _____ Preferred Name: _____
First & Last

Birth Date: _____ Gender: ☐ M ☐ F Grade (as of September 2017): _____
MM /DD / YYYY

Address of Child's Residence: _____
Street Apt / Unit

City:_____ State: _____ Zip: _____

Household Email: _____

Child lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian

Parent / Guardian Information

Mother's Name: _____

Address (if different from children): _____ _____
Street Apt / Unit

City: _____ State: _____ Zip _____

Home phone:_____ Work:_____ Cell:_____

Father's Name: _____

Address (if different from child's): _____
Street Apt / Unit

City: _____ State: _____ Zip: _____

Home phone: _____ Work: _____ Cell: _____

Guardian's Name: _____

Home phone: _____ Work: _____ Cell: _____

Emergency Contact Information, *in the event we cannot reach a Parent.*

Name:_____ Relationship: _____

Home phone: _____ Work: _____ Cell: _____

Name of Child: _____ _____

First *Last*

Health Information

The following information must be completed by the Parent or Guardian.
Provide complete information so that the Church of the Apostles staff can be aware of your child's needs. We recommend that you keep a dated copy of the completed form for your records.

Insurance

Is your child covered by family medical/hospital insurance? ☐ Yes ☐ No

Insurance company: _____ Policy or ID #_____

Name of physician:_____ Phone: _____

Name of dentist/orthodontist: _____ Phone: _____

Allergies: (*List all known)*

Medication allergies: *Describe reaction and management of the reaction.*

1.
2.
3.

Food allergies: Describe reaction and management of the reaction.

1.
2.
3.

Other allergies: Describe reaction and management of the reaction.

1.
2.
3.

Asthma Inhalers and Epi-Pens

Please provide detailed instructions on asthma treatment protocol and use of Epi-Pens.

First Name:_____ ***Last Name***: _____

Current Medications

1. Please list all medication taken <u>regularly</u> (including over-the-counter or non-prescription drugs), **even if a regular dose is not scheduled during the program for which your child is registered.** In the unlikely event of an emergency, we need to be able to provide this information to emergency medical personnel as part of your child's health history.
2. **If your child will need to take medication during the program**, please be sure to send enough medication with your child to last throughout the program. Keep it in the original packaging/bottle that identifies the child, prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. ***Attach additional pages as needed for more medications.***

☐ This child takes **NO** medication on a routine basis.

☐ Identify any medications taken during school year that your child does not /may not take during the summer.

_____

☐ This child currently takes medication as follows:

Med #1: _____ Dosage: _____

Specific times taken each day _____ Reason needed _____

Med #2: _____ Dosage: _____

Specific times taken each day: _____ Reason needed: _____

Med #3: _____ Dosage: _____

Specific times taken each day: _____ Reason needed:_____

Over-the-Counter Medications

*Initial all over-the-counter medications you allow and then **c**hoose [**A**]dult or [**C**]hild for dosage when applicable.*

(Initial)	(A or C)		Initials	(A or C)	
_____	_____	Acetaminophen (Tylenol)*	_____	_____	Ibuprofen (Advil/Motrin)*
_____	_____	Betadine Solution	_____	_____	Hydrogen Peroxide
_____	_____	Antihistamine*	_____	_____	Naproxen (Aleve)*
_____	_____	Dramamine /Bonine	_____	_____	Swimmer's Ear Drops
_____	_____	Decongestant*	_____	_____	Sting Stop for bites
_____	_____	Hydrocortisone Ointment	_____	_____	Antacids
_____	_____	Ibuprofen (Advil/Motrin)*			

Health History for: Name:_____

Do any of the following items apply to your child?	*Yes or No*
Recent injury, illness, or infectious disease?	.
A chronic or recurring illness/condition?	.
Ever been hospitalized?	.
Have frequent headaches?	.
Ever been knocked unconscious?	
Wear glasses, contacts, or protective eye wear?	
Ever had frequent ear infections?	
Ever passed out during or after exercise?	
Ever been dizzy during or after exercise?	
Ever experience motion/car sickness	
Ever had seizures?	
Ever had chest pain during or after exercise?	
Ever had high blood pressure?	
Ever been diagnosed with a heart murmur?	
Ever had back problems?	
Ever had problems with joints (knees, ankles)?	.
Have an orthodontic appliance?	.
Have any skin problems (itching, rash, acne)	
Have diabetes?	
Have asthma?	
Had mononucleosis in the past 12 months?	
Had problems with diarrhea/constipation?	
Have problems with sleepwalking?	
If female, have an abnormal menstrual history?	
Have a history of bed-wetting?	
Ever had an eating disorder?	
Ever had emotional difficulties for which professional help was sought?	

Please explain any "Yes" answers: _____

Name:_____

Immunizations:

Are your child's immunizations up to date? ☐ Yes ☐ No

Date of last Tetanus Shot:_____

Date of last PPD or TB skin test:_____ Result: ☐ Positive ☐ Negative

Physical Limitations

Describe any restrictions to activity (e.g., what cannot be done, what adaptations or modification are necessary.)

_____

Other Helpful Information

Please provide any additional information about your child's physical, emotional, or mental health, or social development that will help us do all we can to help your child have a positive experience with us. If there is anything you would like to discuss, please contact Carlos Pellot at 703-591-1974.

_____

Dietary Restrictions: *Not allergies!*

This section does NOT apply to food allergies. Instead, this section applies only to family preferences or customs. Every effort will be made to accommodate requests for dietary restrictions. If your child has an adverse health reaction to any type of food, please list it in the Allergies section of this form.

☐ Does not eat red meat ☐ Does not eat seafood / shellfish ☐ Does not eat poultry

☐ Does not eat eggs ☐ Does not eat pork ☐ Does not eat dairy products

Health Release Form

The information provided in this document is accurate to the best of my knowledge. On behalf of my child _____ , I give permission to Church of the Apostles Anglican (Apostles) to provide routine health care, administer prescribed medication, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to Church of the Apostles to arrange necessary related emergency transportation for the person named. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Church of the Apostles to secure and administer treatment, including hospitalization, for the person named.

In addition, I give Church of the Apostles staff and volunteers permission to pray with and for my child (named above).

_____ _____

Parent's / Guardian's Signature *Date*

PRINT Parent/Guardian Name:_____

A photocopy of the FRONT and BACK of your child's Health insurance card MUST be attached to this form.

Photo Release Agreement

Regarding permission for Church of the Apostles Anglican to use only for promotional purposes any photos or video material of my child:

_____ _____

First Name Last Name

taken while he/she is a participant in any programs, activities, events, or worship services affiliated with Church of the Apostles Anglican, its Children's Ministry and/or its Youth Ministries:

I understand that the photos or video images may be used in print material, on the church's website at www.ChurchoftheApostles.org, in the e-letter *Apostles News* or on the church's Facebook and Twitter pages.

I also understand that my child's name will NEVER be included with any image that may be used by the church for any reason.

I further reserve my right to withdraw this permission at any time.

 ☐ YES, I grant permission.

_____ _____

P*arent's/Guardian's Signature* *Date*

PRINT Parent/Guardian Name: _____

 ☐ NO, I do NOT grant permission.

_____ _____

Parent's/Guardian's Signature *Date*

PRINT Parent/Guardian Name:_____