



# Youth Medical Form 2019-2020

Office Use Only

Date Accepted \_\_\_\_\_  
Staff Initial \_\_\_\_\_

**Please print and do not leave any questions blank. If they do not pertain to the participant, please write N/A. Incomplete forms will be returned to the parent/guardian for completion. Without a copy of both sides of the insurance card, this document is considered incomplete. This form cannot be scanned or emailed.**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date: \_\_\_\_\_

Gender: \_\_\_\_\_ DOB (MM/DD/YYYY): \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Primary Physician Full Name: \_\_\_\_\_

Primary Physician Phone Number: \_\_\_\_\_

Dentist Full Name: \_\_\_\_\_

Dentist Phone Number: \_\_\_\_\_

Date of Last Tetanus Shot (MM/DD/YYYY): \_\_\_\_\_ (if unknown, write unknown)

Taking Any Medications Currently (use separate sheet if necessary, include epipen & inhaler)? Yes ___ No ___		
Name of Drug	Dosage	Time medication taken

  

Any Medication Allergies? Yes ___ No ___		
Name of Drug	Reaction	Treatment

  

Any Food Allergies? Yes ___ No ___		
Name of Food	Reaction	Treatment

  

Any Environmental Allergies? Yes ___ No ___		
Name of Allergen (ex. grass)	Reaction	Treatment

**Please complete the back of form**

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Does the participant have Asthma? Yes \_\_\_ No \_\_\_

Cause of Trigger

Reaction

Treatment

Does the participant carry a Rescue Inhaler with them at all time? Yes \_\_\_ No \_\_\_

Does the participant carry an EpiPen with them at all time? Yes \_\_\_ No \_\_\_

Does the participant have a physical and/or psychological ailment, illness, weakness, limitation, handicap, disability condition or diagnosis found on the autism spectrum that the La Casa staff or leaders should know about?

Yes \_\_\_ No \_\_\_ If yes, please explain in detail: \_\_\_\_\_

**Insurance Information**

Please provide us a copy of your insurance card, front and back. (Copy can be made at church or emailed to lacasayouth@lacasadecristo.com)

Name of Primary Insured: \_\_\_\_\_ If no insurance, \_\_\_\_\_ (initial)

Name of Employer: \_\_\_\_\_

**Parent/Guardian Information**

Mother/Guardian

Father/Guardian

Full Name: \_\_\_\_\_

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zipcode: \_\_\_\_\_

City, State, Zipcode: \_\_\_\_\_

Preferred Phone Number: \_\_\_\_\_

Preferred Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Emergency Contact Information**

If we cannot contact a parent/guardian in case of an EMERGENCY, please list 2 adults we should contact.

Full Name: \_\_\_\_\_

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zipcode: \_\_\_\_\_

City, State, Zipcode: \_\_\_\_\_

Preferred Phone Number: \_\_\_\_\_

Preferred Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

I understand that I must provide a copy of both sides of the insurance card. \_\_\_\_\_ (initial)

I release and discharge La Casa de Cristo, its volunteers, and staff from any and all liability in connection with accidents or injuries that occur, regardless of the cause. I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under general or special supervision and upon the advice of or to be rendered by a licensed physician, surgeon, and/or dentist. I further agree to pay all charges for dental, medical, and/or hospital care or treatment. I am responsible for the health care decisions and am authorized to consent to the services to be rendered.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_