

**ST. JOHN'S UNITED METHODIST CHURCH**  
**6611 PROCTOR RD. SARASOTA, FL 34241**  
**941-925-2661**

**HEALTH RECORD**

Name (first, middle, last) \_\_\_\_\_

Male \_\_\_ Female \_\_\_\_\_ Age \_\_\_\_\_

Has there been a recent exposure to contagious disease? \_\_\_\_\_

If yes, what and when \_\_\_\_\_

*Any allergies or reactions to:*

Medications? \_\_\_\_\_ Which ones? \_\_\_\_\_

Aspirin? \_\_\_\_\_ Aspirin substitute? \_\_\_\_\_ Insect bites? \_\_\_\_\_ Insect stings? \_\_\_\_\_

Pollen? \_\_\_\_\_ poison ivy or oak? \_\_\_\_\_

Other? \_\_\_\_\_

*Any history of: Congenital deformity or major disability?* \_\_\_\_\_

Describe: \_\_\_\_\_

Chronic infection of nose, throat, ears or sinus? \_\_\_\_\_ Asthma or lung disease? \_\_\_\_\_

Heart disease? \_\_\_\_\_ Diabetes? \_\_\_\_\_ Hernia? \_\_\_\_\_ Tendency to faint? \_\_\_\_\_

Convulsive Seizures/Epilepsy? \_\_\_\_\_ Sleep Walking? \_\_\_\_\_

Bed wetting? \_\_\_\_\_ Athlete's foot? \_\_\_\_\_

Has girl menstruated? Yes \_\_\_ no \_\_\_ Have irregular or painful menses? \_\_\_\_\_

Any recent operations, serious injuries or illness? \_\_\_\_\_ Describe \_\_\_\_\_

Other: \_\_\_\_\_

*List present medications:* \_\_\_\_\_

What restrictions, if any, should be observed in active camp life for your child?

Tetanus inoculation date: \_\_\_\_\_

(Child **must** have had series of DPT, DT or Tetanus booster in past five years.)

Please attach copy (front/back) of health insurance card. Copy of card attached? \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Completed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

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