

Health and Medications Form
University Lutheran Church

PLEASE CHECK IF ANY OF THE FOLLOWING CONDITIONS EXIST

Asthma

Heart Condition

Psychological Disorders

Diabetes

Seizure Disorder

Hearing Impairment

Epilepsy

Medication Allergy

Vision Impairment

Other

Is your child under current medical treatment? Yes No If yes, please describe:

Please list any allergies _____

Are there any medications that your child is currently taking? Yes No

If yes, please describe: _____

I, the parent/guardian of _____

give permission to ULC youth leaders to dispense the following over-the-counter medications to my child (Please circle):

Tylenol Ibuprofin Tums

Parent/Guardian's Signature _____ Date _____