HEALTH HISTORY AND MEDICAL RELEASE FORM

Participant's Name _____ Sex _____ Birthdate _____ Age _____

Parent/Guardian _____ Relationship _____

Street Address _____ City/State _____ Zip _____

Home Telephone _____ Work Phone _____

HEALTH HISTORY

Family Doctor _____ Phone _____

Allergic Reactions: _____

_____

Please indicate any other medical problems/situations pertinent to your child:

_____

Any physical limitations? _____ if yes, explain _____

_____

Any emotional/psychological limitations or reactions to be aware of? _____ If yes, explain:

Is the student presently taking any medication? _____ All medication is to be well labeled with clear, concise directions indicated here (frequency, dosage, etc.):

In an EMERGENCY, and if unable to reach parent/guardian, we should contact:

1. Name _____ Phone _____
2. Name _____ Phone _____

PERMISSION FOR ROUTINE MEDICAL TREATMENT

All attempts will be made to notify you if your child requires medical treatment (i.e., cases of high, persistent fever; severe vomiting, etc.) Please indicate whether or not you wish attempts to be made to contact you if your child becomes ill with minor symptoms (ie. headache, sore throat, low grade fever, etc.). YES _____ NO _____

We do not wish to give any medical treatment to your son/daughter against your wishes or family practice. Please read each of the following statements carefully and sign only either A or B which is in accord with your wishes:

A. I grant permission for non-prescription medication (i.e., Tylenol, cough syrup, etc.) and routine non-surgical medical care to be given to my child, if deemed advisable by the designated supervisor(s).

Signature _____ Date _____

OR

B. I so not want ANY type of medication administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature _____ Date _____

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

In case of emergency, I hereby give permission to transport my child to the nearest hospital/emergency center for emergency medical or surgical treatment. I will be contacted as soon as possible and will be advised prior to any further treatment by the hospital or doctor.

Signature _____ Date _____

Family Insurance Provider/Health Plan _____

Health Plan Number (include expiration date): _____