

Medical Information Form

SECTION 1 - Required

Medical Information

Participant's full legal name: _____ Birth date: _____

Parent phone(home): _____ Parent phone(work): _____

Parent phone(cell): _____

Mailing address: _____

Primary care physician's name: _____ Physician's phone: _____

Physician's address: _____

INFORMATION NEEDED ABOUT PARTICIPANT (Required):

YES	NO	If yes, please list / explain below. Attach additional sheets if needed.
		Does the participant have any chronic health problem or illness?
		Does he or she have any acute illness now?
		Has the participant been treated recently for some medical problem?
		Is the participant taking any medications for treatment of a medical problem?
		Does the participant have any allergies to medication or local anesthetics?
		Does he or she have any allergies? If Yes, List them:

SECTION 2 - Required

Official Medical Treatment Authorization

I recognize that while attending this program, medical treatment on an emergency basis may be necessary for my child, and I further recognize that volunteers or staff overseeing the program may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the circumstances and to assume the expenses of such care. I also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Parent / Guardian Signature: _____ **Date:** _____

Participant must sign if over 18.