Youth (under 18) Medical Information Form

(CONFIDENTIAL - FOR STAFF/ADMINISTRATION USE ONLY)

Trip/Program : _____ Date: _____

Participant's Name: _____ Date of Birth: _____
❑ Male ❑ Female

Health Care Provider: _____ Policy #: _____
Doctor's Name: _____ Phone Number: _____

Parent or Guardian's Name(s): _____
Address: _____
Phone Number: (home) _____ (work) _____

Emergency Contact(s) : _____
Phone Number: (home) _____ (work) _____

Does your child wear glasses ? contact lenses?

Does your child have any allergies that our staff should be aware of? (check any that apply)
❑ Penicillin ❑ Aspirin
❑ Plants ❑ Tylenol
❑ Insect Bites ❑ Any other drugs? _____
❑ Bee Stings

Food Allergies? _____

Please indicate if your child has any of the following conditions (check any that apply):

❑ Asthma Does your child use an inhaler? ❑ yes ❑ no
Type of Inhaler: _____

❑ Fainting ❑ Headaches ❑ Toothaches ❑ Ear aches ❑ Cramps

❑ Re-current bone, joint/muscle injuries ❑ Sleepwalking/talking ❑ Susceptibility to Cold
If yes, please explain: _____
_____

Any other health problems or conditions? ❑ yes ❑ no
If yes, please explain: _____

Does your child take any medications? ❑ yes ❑ no
If yes, please explain when and how they are to be taken: _____
_____

Are there any behavioral/mental health problems that we should know about? ❑ yes ❑ no
If yes, please explain what they are and how we can best deal with them: _____
_____

Is there anything else you would like us to know about your child? (Dietary preferences, etc?)_____
_____

The above information is correct and complete to the best of my knowledge.

_____ _____
Signed by parent or guardian for children under 18 Date