SUMMER PROGRAMS MEDICAL FORM

Boys State

Please Print or Type

Full Name_____ Age_____ Birth Date____/____/____
Last First Middle M D Y

Home Address_____Phone _____
Box # or Street City State Zip area code

Name, Relationship of Parent or Guardian:_____

Address_____
Box # or Street City State Zip

Parent or Guardian's Phone Number: Day_____Night _____

Name, Address & Phone of
Family Physician _____

IN CASE OF EMERGENCY PLEASE CONTACT:

Name:_____(Relationship to delegate):_____

Phone number, Day _____Evening _____

HEALTH INSURANCE INFORMATION REQUIRED: (**A copy of the insurance card, front and back, and the prescription drug card, if applicable, front and back, must be included with this form**)

Name of Ins. Co._____Subscriber's ID No._____Grp. No._____

Address of Ins. Co._____Subscriber's Name:_____

Other:_____

AUTHORIZATION AND CONSENT:

I hereby agree that the attending physician or whomever he or she may designate may undertake treatment, including operations and/or the administration of necessary anesthesia, in serious or major illnesses or injuries without prior notification of the undersigned or any other person, and without obtaining consent of the undersigned or any other person, if in the judgment of the physician or designee it is necessary for health care reasons to proceed with the treatment without delay. I further agree that the attending physician or whomever he or she may designate may evaluate and treat all other injuries or illnesses for which help is sought. In the case of a minor (under 18 years of age) individual, this treatment may proceed without prior notification of the undersigned parent or guardian, although every attempt will be made to notify the parent or guardian in the event of such an injury or illness. I also agree that needed immunizations may be administered. I further agree that any medical information may be released to other health care providers who may be providing care.

***Signature of summer program participant: _____**

***Signature of minor's parent or guardian: _____**

Date:_____

(*This section must have signatures of participant **and** parent or guardian if participant is a minor under the age of 18)

(over)

PERSONAL HISTORY - Comment on all positive answers under remarks.

HAVE YOU HAD?	Yes
Allergy to:	
Penicillin	
Sulfonamides	
Peanuts	
Bees, wasps	
Other	
Specify:	
Infectious mononucleosis	
Tropical Disease (specify)	
Chicken pox/Varicella	
Respiratory disorders, including asthma	
High blood pressure	
Diabetes, thyroid, endocrine problems	

HAVE YOU HAD?	Yes
Stomach or intestinal Disorders	
Blood Disorders, including anemia	
Headaches, Migraines	
Hearing disabilities	
Current prescription medicines (list)	
Current non-prescription medicines (list)	
Current vitamins or supplements (list)	
Smoking or other tobacco use	
Surgery or serious injury	

HAVE YOU HAD?	Yes
Chronic Medical Condition (specify)	
Vision, corrective lens	
Cancer	
Heart Disease	
Serious head injury	
Hepatitis B	
Hepatitis C	
Kidney diseases	
Neurological disorder	
Depression, anxiety	
Other psychological problem	
Seizure	
Limited physical activity	
Organ loss	

Remarks:_____

TO PARTICIPANT, PARENTS OR GUARDIANS

Is this participant capable of carrying a full program of fitness activities, including sports of all kind? ☐ Yes ☐ No
If "No", please state limitations below:

Is there anything else about this participant that we should know? ☐ Yes ☐ No If "Yes", explain:

Do you. have any recommendations regarding the care of this participant? ☐ Yes ☐ No If "Yes", explain:

Is the participant now under treatment or on medication for any medical or emotional condition, or does he any require special medical attention?

☐ Yes ☐ No

Explain below

Date_____ **Signature**_____

Parent, or Guardian