SUMMER PROGRAMS MEDICAL FORM

Boys StatePlease Print or Type

Full Name						Age	Birth Da	te	/	_/
	Last	First		Middle				M	D	Y
Home Address						Phone				
Box # or Street			City		Zip	area c				
	ip of Parent or Guardian:									
AddressBox	x # or Street		City			State			Zi	
Parent or Guardian's Phone Number: Day			-							•
Name, Address & Family Physician	Phone of									
IN CASE OF E	EMERGENCY PLEA	ASE CONTA	ACT:							
Name:			(Relationship to delegate):							
Phone number, Da	ay			Evening	5					
Name of Ins. Co	on drug card, if app		Subscri	ber's ID No.	•		Grp. No			
Address of Ins. Co)		Subscriber's Name:							
I hereby agrand/or the administration or any other personal designee it is need physician or whom case of a minor (uguardian, although that needed immus providers who massed in the signature of signat	on AND CONSENT: the ethat the attending phystration of necessary and on, and without obtaining the cessary for health care in the every for health care in the every attempt will be not be a providing care. Summer program print or grant	sician or whom sthesia, in seric ag consent of the reasons to pro- ignate may eva- dividual, this the made to notify istered. I further participant:	never he or bus or majo the undersigneed with aluate and treatment m the parent her agree the	she may de or illnesses of gned or any the treatme creat all othe ay proceed or guardian that any med	esignate mor injuries of other peent withou er injuries without p in the evilical infor	nay undertake to without prior re- reson, if in the at delay. I fur or illnesses for rior notification ent of such an emation may be	reatment, indication of judgment of the agree of which help nof the undinjury or illustrated to	cluding of the u f the p that th o is sou ersigne ness.	g oper under physica ne atte ught. ed par I also healt	rations rsigned cian or ending In the rent or agree th care
	st have signatures of par				icipant is	a minor under t	the age of 18	3)		_
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$\label{personal} \textbf{PERSONAL HISTORY} \ \textbf{-} \ \textbf{Comment on all positive answers under remarks.}$

HAVE YOU HAD?	Yes	HAVE YOU HAD?	Yes	HAVE YOU HAD?	Yes
Allergy to:		Stomach or intestinal Disorders		Chronic Medical Condition (specify)	
Penicillin		Blood Disorders, including anemia		Vision, corrective lens	
Sulfonamides		Headaches, Migraines		Cancer	
Peanuts				Heart Disease	
Bees, wasps		Hearing disabilities		Serious head injury	
Other		Current prescription medicines (list)		Hepatitis B	
Specify:				Hepatitis C	
				Kidney diseases	
Infectious mononucleosis		Current non-prescription medicines (list)		Neurological disorder	
Tropical Disease (specify)				Depression, anxiety	
Chicken pox/Varicella		Current vitamins or supplements (list)		Other psychological problem	
Respiratory disorders, including asthma				Seizure	
High blood pressure		Smoking or other tobacco use		Limited physical activity	
Diabetes, thyroid, endocrine problems		Surgery or serious injury		Organ loss	
Is this participant capable of carry If "No", please state limitations b		program of fitness activities, includi	ng sports (of all kind? ☐ Yes ☐ No	
Is there anything else about this p	articipant	that we should know? ☐ Yes	□ No	If "Yes", explain:	
Do you. have any recommendation	ns regard	ing the care of this participant?	Yes	No If "Yes", explain:	
attention? ☐ Yes ☐ No	ment or or	n medication for any medical or emor	tional cond	lition, or does he any require special	nedical
Explain below					
Date		Signature			

Parent, or Guardian