**SUMMER PROGRAMS MEDICAL FORM**
**Student Trooper 2024**
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 | |
| **Concussions** | |
| Hearing disabilities | |
| Current prescription medicines (list) | |
| **Must be listed to attend**. | |
| | |
| 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 | |

If any explanation is needed, enter here. _____

_____

**If <u>YES</u> is checked on any of the boxes above, a Physician's approval and signature to attend the program and be able to participate in all exercises listed below must be obtained.**

_____

**Physician's Signature approving student to participate**

| EXERCISE | EXERCISE | EXERCISE | EXERCISE | EXERCISE |
|---|---|---|---|---|
| Jumping Jacks (10) | Forward Bends (2) | Leg Raises (10) | Sit Ups (10) | Jumping Jacks (25) |
| Toe Touches (2) | Hamstring Stretch (2) | Speed Run (1/4 mile) | Back Extensions (10) | Push Ups (10) (10) |
| Groin Stretch (2) | Neck Stretch (2) | Distance Run (1 mile) | Arm Rotations (4 sets) | |

Multiple repetitions for at least 1 hour, plus 1 mile run, Monday thru Friday.

TO PARTICIPANT, PARENTS OR GUARDIANS

Is this participant capable f carrying a full program of fitness activities, including calisthenics, jogging, marching, and 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 patient now under treatment or medication for any medical or emotional condition, or any required special medical attention ☐ Y ☐ No
EXPLAIN BELOW

_____

Date_____ Signed_____
Participant, Parent, or Guardian

IMMUNIZATIONS

A. DPT series:___/____/____ ____/____/____ ____/____/____ and Td booster:____/____/____
M D Y M D Y M D Y M D Y
(within 10 years)

B. Measles, Mumps., Rubella (MMR) - 2 DOSES. 1. ____/____/____ 2. ____/____/____
M D Y M D Y

OR

Rubeola (Measles) - 2 doses: 1. ____/____/____ 2. ____/____/____ Rubella _ __/____/____ Mumps: ____/____/____
M D Y M D Y M D Y M D Y

C. Oral Polio series (if under l8 years of age): ☐ Yes ☐ No Booster____/____/____
M D Y

D. Tuberculin skin test (within past 12 months): ____/____/____ Result:*_____, ____/____/____
M D Y M D Y

E. (Recommended) Hepatitis B vaccine - 3 doses: 1. ____/____/____ 2. ____/____/____ 3. ____/____/____
M D Y M D Y M D Y

F. (Recommended) Varicella vaccine - 2 doses: 1. ____/____/____ 2. ____/____/____
M D Y M D Y

G._____ _____ ____/____/____
**Physician, School or Public Health Clinic** **Physician/Authorized Signature required** Date

_____
Address

(_____)_____
Phone

*If result is positive, attach record of treatment. .