Sample 19 MEDICAL INFORMATION FORM

To ensure that all information on this form is as complete as possible, the form should be completed and signed approximately one week after acceptance into the Youth Program and before attending any external activities. Completed forms should be returned to the OFFICER-IN-CHARGE.

Please print

Name ______________________ Date of Birth __________ Sex ______

Address ____
Street Apt. No.

City/Town ____________________ Postal Code ______________

Telephone Number ______________________________________
Home Other

Emergency Contact ______________________________________
Name Relationship

Telephone Number ______________________________________
Daytime Evening

Doctor's Name ____________________ Telephone ____________

Health Insurance Number ______________________________

MEDICAL HISTORY

1. Do you (your child) have special dietary requirements or are you (your child) subject to any allergies (drugs, food, insect stings, etc.)? If so, please list them indicating type of reaction and usual treatment.

2. Are you (your child) subject to any of the following conditions at present? (Please check mark ✓ all that apply)

❑ Asthma	❑ Ear Trouble	❑ Hay Fever	❑ Nightmares
❑ Bed Wetting	❑ Fainting	❑ Headaches	❑ Sleepwalking
❑ Bronchitis	❑ Fear of heights	❑ Menstrual Cramps	❑ Tonsillitis
❑ Convulsions	❑ Frequent Colds	❑ Motion Sickness	❑ Nosebleeds
			❑ Other (indicate) ______

Please explain the usual treatment for any conditions indicated:

3. Please check mark ✓ the following factors applicable to you (your child) which the leaders should know:

Illnesses		Operations	Immunizations
❑ Heart Disease	❑ Rheumatic Fever	❑ Appendectomy	❑ German Measles
❑ Hepatitis	❑ Mononucleosis	❑ Tonsillectomy	❑ Measles
❑ Pleurisy	❑ Tuberculosis		❑ Mumps
❑ Pneumonia	❑ Epilepsy		❑ Whooping Cough
			❑ Poliomyelitis

Note any recent illnesses, chronic conditions, operations, or injuries not included above and indicate any medication or treatment necessary:

4. The Youth Program sometimes includes sports, swimming, hiking, and other physical activities. Would anything prevent you (your child) from fully participating in such a program? ❑ Yes ❑ No
   If **Yes**, please state the particulars:

5. Has your daughter started menstruating? ❑ Yes ❑ No
   If **No**, has menstruation been explained to her? ❑ Yes ❑ No

6. Date of last tetanus shot __________ (day/month/year)

7. Can you (your child) take acetaminophen? (e.g. Tylenol) ❑ Yes ❑ No

8. **FOR EXTENDED OUTINGS** (e.g. camping), what medication(s) would you (your child) be bringing? These must be clearly labelled with the patient's name, dosage, and frequency. Please indicate any medications that must be kept with you (your child) at all times (e.g. medications for severe allergic reactions). For children away on an extended outing, it is recommended that all other medications be handed to the Officer-in-Charge, to ensure that medication schedules are correctly followed.

A. MEMBERS UNDER 18 YEARS OF AGE

As the parent/guardian responsible for the above-named person, I hereby state that the above mentioned information is true, to the best of my knowledge. I authorize the officer(s)-in-charge to secure such medical advice and services as may be deemed necessary for the health and safety of my child.

____

Signature of parent or guardian

____

Date

B. MEMBERS 18+ YEARS or 16-17 YEARS OF AGE Not Residing With A Parent Or Guardian

I hereby state that the above mentioned information is true, to the best of my knowledge. I authorize the officer(s)-in-charge to secure such medical advice and services as may be deemed necessary for my health and safety.

____

Signature of member

____

Date