EMERGENCY MEDICAL INFORMATION (RELEASE FORM FOR MINORS ON BACK)

Name: _____ Age _____ Gender: Male/Female

Address: _____ Home Phone _____

Parent's Name(s): _____ Other Phone Numbers:

Work: Mom_____ Dad_____ Cell: Mom _____ Dad_____

GENERAL HEALTH INFORMATION

Do you have: (If yes – explain)

__Yes __No Allergies? _____

__Yes __No Heart Condition?_____

__Yes __No Other?_____

Are you subject to: (If yes – explain)

__Yes __No Fainting? _____

__Yes __No Sleep walking? _____

__Yes __No Upset stomach? _____

__Yes __No Other? _____

Do you have a reaction to: (If yes – explain)

__Yes __No Bee sting? _____

__Yes __No Penicillin? _____

__Yes __No Other drugs? _____

__Yes __No Other? _____

__Yes __No Do you have any serious illness or surgery within the past ten years? _____

_____

__Yes __No Do you have any condition that would prevent you from participating n any activities?

_____

__Yes __No Do you take any prescription medication? Please list: _____

__Yes __No Are you diabetic?
__Yes __No Do you have any sight or hearing impairment?
__Yes __No Do you wear contact lenses?
__Yes __No Are all your immunizations current including tetanus?
Please indicate ANYTHING else that leaders should know to help avoid or deal with any health situation that might arise:

_____

Emergency Information: ALL PARTS MUST BE INCLUDED

Health Insurance Co. _____ Policy No._____

Group # _____ Insurance Phone _____

Emergency Contact Person: _____ Relationship _____

Address: _____

Phone: Home _____ Work _____ Cell _____

Family doctor _____ work phone _____

Emergency phone _____other phone ? _____