

# Medical Information Form

In order to best care for your student(s) it is necessary for you to provide written authorization for the chaperones or directors to consent to emergency medical treatment for your children if you are not available.

Student Name \_\_\_\_\_ Parents Name \_\_\_\_\_  
Address \_\_\_\_\_ Birthdate \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ General Physical Condition is \_\_\_\_\_

Has the Student;

been hospitalized? \_\_\_\_\_ for \_\_\_\_\_ date \_\_\_\_\_

had surgery? \_\_\_\_\_ for \_\_\_\_\_ date \_\_\_\_\_

had a tetanus shot? \_\_\_\_\_ date of last booster \_\_\_\_\_

been wearing glasses? \_\_\_\_\_ contacts? \_\_\_\_\_

been taking any kind of medication? \_\_\_\_\_ for \_\_\_\_\_

Name of any prescription medications \_\_\_\_\_

Name of student's Physician \_\_\_\_\_ phone \_\_\_\_\_

Dentist \_\_\_\_\_ phone \_\_\_\_\_

Emergency contact \_\_\_\_\_ phone \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

Please circle any areas below where there should be any particular medical considerations for this student. Please attach a written description of concerns or recommended medical procedures that should be considered for this student.

major illness    major injury    muscles    eyes    skin    skeletal

dental    diabetes    internal    allergies    epilepsy    other

\_\_\_\_\_  
\_\_\_\_\_