CONFIDENTIAL

YOUTH EMERGENCY MEDICAL INFORMATION

PARTICIPANT'S NAME:

_____

HEALTH INFORMATION STATEMENT

Check below any information you feel staff and/or volunteers may need, to maximize the safety and the well being of the participant and others. To the right of the condition statement is space for more information relating to the condition checked. Please be specific. In case of emergency, this health information may be the only source of accurate, important information.

[ ] Nervous or Mental (epilepsy, emotional stress, convulsions) _____
_____

[ ] Lung Disease (asthma, persistent cough, tuberculosis) _____
_____

[ ] Disease of Heart or Blood Vessels, Increased or Abnormal Blood Pressure_____
_____

[ ] Pain in Chest or Shortness of Breath (heart murmur, rheumatic fever) _____
_____

[ ] Stomach or Intestinal Trouble (ulcers, gall bladder or liver disorder, jaundice, hernia, colitis)
_____

[ ] Arthritis, Diabetes, Kidney or Bladder Disease _____
_____

[ ] Hay Fever or Allergies _____
_____

[ ] Allergy to Medicines (including penicillin, tetanus) _____
_____

[ ] Impaired Sight or Hearing, Chronic Ear Infections_____
_____

[ ] Recent Surgical Operation, Accidents or Injuries_____
_____

[ ] Any Infectious Disease_____
_____

[ ] Skin Disease_____
_____

[ ] Allergy to Foods_____
_____

[ ] Currently taking Medicines (list names & doses) _____
_____

[ ] Medication that needs refrigeration _____
_____

[ ] Under on-going care of a Physician (NAME & PHONE #) for chronic or recurring problem
_____

[ ] Do you wear glasses? YES[ ] NO[ ] SOMETIMES[ ]
[ ] Do you wear contact lenses? YES[ ] NO[ ] SOMETIMES[ ]
[ ] Date of last TETANUS BOOSTER_____
[ ] Date of last FLU SHOT _____
[ ] Significant Orthopedic and/or Neuromuscular Impairment (e.g. loss of limb, spinal cord injury)
_____

Primary Care Physician: _____
Phone: _(____)_____-_____

Health Insurance Provider: _____
Owner's Name: _____ ID/Policy Number: _____

SIGNED:_____ **DATE**:_____
Parent or Guardian