

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