

Medical / Health Information

Name _____ Birthdate _____ Sex _____ Age _____

Parent or Guardian _____ Home Phone _____

Home Address _____ Work Phone _____

City _____ Zip _____

Emergency Contact (other than parent) _____ Phone _____

Family Physician _____ Phone _____

Under doctor's care now? _____ If yes, please explain on back

Prescribed medicine _____ (All meds must be turned in to chaperone or camp nurse)

Allergies to medications? _____ List _____

Health History Is youth subject to: Indicate **YES** or **NO**

_____ Hernia	_____ Hay Fever	_____ Nervous Disorders	_____ Asthma
_____ Frequent Colds	_____ Fainting Spells	_____ Sleepwalking	_____ Ear/Sinus
_____ Allergies	_____ Insect Stings	_____ Drug Sensitivity	_____ Enuresis
_____ Epilepsy	_____ Heart Trouble	_____ Diabetes (take insulin?) (bed wetting)	
_____ Bleeding /clotting disorders	_____ Food Allergies		

If **YES** on any of the above, please explain _____

Has the youth had:

_____ Poliomyelitis	_____ Hay Fever	_____ Rheumatic Fever
_____ Appendicitis Attack	_____ Measles	_____ Mumps
_____ Chicken Pox	_____ Whooping Cough	_____ Scarlet Fever

Is the youth pregnant? _____ Date of Last Tetanus Booster: _____

Identify any physical/emotional problems that would prevent full participation in the program.

Emergency Authorization: I hereby give my permission to the medical staff selected by the Cooperative Extension Service faculty / staff to order x-rays, routine tests and treatment for the above named youth. In the event I cannot be reached in an emergency, I hereby give my consent to emergency medical treatment, hospitalization or other medical treatment as needed. I will assume all financial obligations incurred if not covered by insurance.

Signature of parent / guardian

Date