

Sample 19 MEDICAL INFORMATION FORM

To ensure that all information on this form is as complete as possible, the form should be completed and signed approximately one week after acceptance into the Youth Program and before attending any external activities. Completed forms should be returned to the OFFICER-IN-CHARGE.

Please print

Name _____ Date of Birth _____ Sex _____

Address _____
Street Apt. No.

City/Town _____ Postal Code _____

Telephone Number _____
Home Other

Emergency Contact _____
Name Relationship

Telephone Number _____
Daytime Evening

Doctor's Name _____ Telephone _____

Health Insurance Number _____

MEDICAL HISTORY

1. Do you (your child) have special dietary requirements or are you (your child) subject to any allergies (drugs, food, insect stings, etc.)? If so, please list them indicating type of reaction and usual treatment.

2. Are you (your child) subject to any of the following conditions at present? (Please check mark ✓ all that apply)

<input type="checkbox"/> Asthma	<input type="checkbox"/> Ear Trouble	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Nightmares
<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Fainting	<input type="checkbox"/> Headaches	<input type="checkbox"/> Sleepwalking
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Fear of heights	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Motion Sickness	<input type="checkbox"/> Nosebleeds
			<input type="checkbox"/> Other (indicate)

Please explain the usual treatment for any conditions indicated: _____

3. Please check mark ✓ the following factors applicable to you (your child) which the leaders should know:

- | Illnesses | | Operations | Immunizations |
|--|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Tuberculosis | | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Epilepsy | | <input type="checkbox"/> Whooping Cough |
| | | | <input type="checkbox"/> Poliomyelitis |

Note any recent illnesses, chronic conditions, operations, or injuries not included above and indicate any medication or treatment necessary:

4. The Youth Program sometimes includes sports, swimming, hiking, and other physical activities. Would anything prevent you (your child) from fully participating in such a program? Yes No
If **Yes**, please state the particulars:

5. Has your daughter started menstruating? Yes No
If **No**, has menstruation been explained to her? Yes No

6. Date of last tetanus shot _____ (day/month/year)

7. Can you (your child) take acetaminophen? (e.g. Tylenol) Yes No

8. **FOR EXTENDED OUTINGS** (e.g. camping), what medication(s) would you (your child) be bringing? These must be clearly labelled with the patient’s name, dosage, and frequency. Please indicate any medications that must be kept with you (your child) at all times (e.g. medications for severe allergic reactions). For children away on an extended outing, it is recommended that all other medications be handed to the Officer-in-Charge, to ensure that medication schedules are correctly followed.

A. MEMBERS UNDER 18 YEARS OF AGE

As the parent/guardian responsible for the above-named person, I hereby state that the above mentioned information is true, to the best of my knowledge. I authorize the officer(s)-in-charge to secure such medical advice and services as may be deemed necessary for the health and safety of my child.

Signature of parent or guardian

Date

B. MEMBERS 18+ YEARS or 16-17 YEARS OF AGE Not Residing With A Parent Or Guardian

I hereby state that the above mentioned information is true, to the best of my knowledge. I authorize the officer(s)-in-charge to secure such medical advice and services as may be deemed necessary for my health and safety.

Signature of member

Date