



**MEDICAL HISTORY AND CONSENT FOR EMERGENCY MEDICAL TREATMENT**

**Directions: Parents/Guardians of minors must complete this form for program staff to provide routine health care and seek emergency medical treatment. Please answer all questions.**

<b>PARTICIPANT INFORMATION</b>	
Participant's Name: _____	Gender: _____
Home Address: _____	Date of Birth: _____
City/State/Zip _____	Home phone: _____
Name of Program Attending: _____ From: ___/___/___ to ___/___/___	

**EMERGENCY NOTIFICATION (PARENT OR GUARDIAN)**

Before a participant under 18 years of age can be treated, the law requires us to obtain parent/guardian consent for treatment. Accordingly, for the safety and well-being of the participant, please provide us with as many phone numbers as possible.

<b>PRIMARY CONTACT</b>	<b>SECONDARY CONTACT</b>
Name: _____	Name _____
Relationship: _____	Relationship: _____
Phone #1: _____	Phone #1: _____
Phone #2: _____	Phone #2: _____

<b>PHYSICIAN INFORMATION</b>	<b>DENTIST INFORMATION</b>
Family Physician: _____	Family Dentist: _____
Address: _____	Address: _____
Phone: _____	Phone: _____

**MEDICAL HISTORY – Please indicate if the participant has any chronic childhood conditions or diseases related to the following and list details, including any activity restrictions in the space provided.**

<input type="checkbox"/> Arthritis & Rheumatological Conditions <input type="checkbox"/> Asthma <input type="checkbox"/> Bones & Muscles <input type="checkbox"/> Brain & Nervous System <input type="checkbox"/> Cancer & Tumors <input type="checkbox"/> Digestive System <input type="checkbox"/> Ears, Nose, Throat/Speech, & Hearing <input type="checkbox"/> Endocrine Glands, Growth & Diabetes	<input type="checkbox"/> Genetic, Chromosomal & Metabolic conditions <input type="checkbox"/> Heart & Blood Vessels <input type="checkbox"/> Kidney & Urinary System <input type="checkbox"/> Learning Disorders <input type="checkbox"/> Lungs & Respiratory System <input type="checkbox"/> Skin Disorders
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Details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Participant's Name:** \_\_\_\_\_

**ALLERGIES:** \_\_\_ this person has NO allergies OR \_\_\_ this person has allergies as noted below

TYPE (INSECT, FOOD, MEDICATION)	DESCRIBE REACTION

\_\_\_ **This person carries an EpiPen**

**MEDICATIONS:** \_\_\_ this person takes NO medications OR \_\_\_ this person takes medication noted below

MEDICATIONS	DOSAGE	FREQUENCY	DIAGNOSIS

NOTE: Our program staff is unable to administer any medication, prescriptions or non-prescription, to participants without a signed Permission to Dispense Medication by Camp Program Staff Form.

DISABILITY – Please indicate if participant is handicapped or disabled in any way:

\_\_\_ Psychological \_\_\_ Neurological \_\_\_ Hearing \_\_\_ Pulmonary \_\_\_ Learning \_\_\_ Mobility \_\_\_ Other

CURRENT MEDICAL CONDITIONS: Please indicate if participant currently has any medical conditions or limitations that do not constitute a handicap or disability that would impair or limit the participant from fully engaging in the activities of the camp for which the participant is registering, and provide a complete description of such conditions or limitations: \_\_\_\_\_

\_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Name of Policy Holder: \_\_\_\_\_  
 Policy Holder ID #: \_\_\_\_\_  
 Medical Insurer Name: \_\_\_\_\_  
 Group Name: \_\_\_\_\_ Group ID #: \_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT**

In the event reasonable attempts to contact me are unsuccessful, PERMISSION is hereby granted for the examination, treatment and medical care of the participant by Henry County Hospital or another duly licensed healthcare facility. PERMISSION is also granted to execute on behalf of the participant any admission or consent forms needed to obtain such treatment. By signing below, I agree that I have read the foregoing and consent to the terms and conditions as stated.

Signature of Parent/Guardian \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_