HEALTH INFORMATION FORM

MEDICAL INSURANCE

NAME OF POLICY HOLDER ____

POLICY # ____

INSURANCE COMPANY ____

HEALTH INFORMATION

OPERATIONS (APPROXIMATE DATES) ____________________________________

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ALLERGIES (INSECT, FOOD, DRUG, POISON IVY, ETC.) _____________________

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SPECIAL MEDICAL PROBLEMS (HEART, KIDNEY, ASTHMA, DIABETES, SEIZURE DISORDERS, ETC.) ____

WHAT MEDICATION IS THIS PERSON TAKING? HOW OFTEN AND FOR WHAT REASON?) ____

DATE OF LAST TETANUS TOXOID IMMUNIZATION ________________________

PARENT AUTHORIZATION

THIS HEALTH INFORMATION IS CORRECT SO FAR AS I KNOW AND THE PERSON HEREIN DESCRIBED HAS PERMISSION IN ALL PRESCRIBED ACTIVITIES EXCEPT AS NOTED BY ME. IN THE EVENT THAT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE MY PERMISSION TO THE PHYSICIAN SELECTED BY THE ADULT LEADER IN CHARGE TO PERFORM OR OBTAIN ALL THE NECESSARY MEDICAL TREATMENT FOR THE ABOVE NAMED YOUTH. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE MEDICAL TREATMENT OF MY CHILD.

SIGNATURE __________________________ DATE _______________________________