Medical and Emergency Contact Form

Participant's Name _____ Date _____

HEALTH INFORMATION

Do you have or have you had:	YES	NO
Recent Serious Injury	○	○
Recent Surgery	○	○
Chronic Medical Condition	○	○
Other Health Concerns	○	○

If YES to any of the above, please describe: _____

_____

_____

Date of last Tetanus Shot? _____

Special Diet? _____

Allergies

Food _____ Drugs _____

Insect Stings/Bites _____ Other _____

EMERGENCY CONTACT INFORMATION

Person to Notify in the Event of Emergency _____ Relationship to Student _____

Emergency Contact Phone Number:

Daytime _____ Evening _____ Other _____

Is participant covered by personal/family medical insurance? ○ Yes ○ No

If yes, name of insurer: _____

Member ID _____ Group # _____ Primary Insured _____

Parent/Guardian Signature: _____ Date _____