HEALTH FORM
And Medical Treatment Release Form

NAME ____ BIRTHDATE ________________

ADDRESS __________________________________ CITY _________________ ZIP _______

HOME PHONE ______________________ ALTERNATE PHONE ______________________

PAGER/CELL/ OTHER ____

EMERGENCY CONTACT: ___________________________ PHONE: __________________

FAMILY PHYSICIAN: ____

ADDRESS: ____ PHONE: __________________

HEALTH INSURANCE COM: ____

POLICY #'S ____

Is there any special dietary or medical requirements: i.e. asthmatic, diabetic, hypoglycemic ? Yes / No
If yes, please describe condition and specific needs.

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Are there any restrictions or recommendations?

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Please indicate if your son/daughter is on any kind of medication? (For what medical problem, what kind of medication, dosage, special instructions, i.e. with meals, etc.

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____

Does your son/daughter have any allergies? What are they and what are their symptoms? What treatment do they take for their allergies?

____

____

Is your son/daughter allergic to any medications or drugs? I.e. penicillin, antibiotics including antibiotic ointments? ____

Immunization history: please include dates
DPT Booster _________________ Tetanus _______________ Polio __________________

PAST ILLNESSES: (Check mark the ones that apply)

Asthma _____ Convulsions _____ Heart Trouble _____ Rheumatic Fever ____
Diabetes _____ Bronchitis _____ Kidney Trouble _____ Sinusitis _____
Hay Fever _____ Fainting _____ Allergy to Bee Sting _____
Allergy to Poison Ivy ______

Medical Treatment Release

As a parent/guardian, I do hereby authorize the treatment by a qualified and licensed Medical physician, selected by the YouthVille staff, in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed, to hospitalize, secure proper treatment for and to authorize injection, anesthesia or surgery for my son /daughter ____________________. This authority is granted only after a reasonable effort has been made to reach me.

In signing this application, I hereby certify that the above information is correct and give permission for my son/daughter to be transported to and from a medical facility in the case of a medical emergency, and for the release of medical records to an attending physician in case of illness.

In case of medical emergency, I understand that every effort will be made to contact parents or guardians of participants. In the event that I cannot be reached, I hereby give permission to the physician selected by the YouthVille staff to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my son/daughter, as named herein.

In addition, I understand that no medication for pain relief such as Tylenol, Advil or aspirin will be dispensed by the staff unless in a medical emergency situation. Accordingly, I hereby give my son/daughter permission to take __________________ (list type of pain reliever you will be sending with your son/daughter) according to the prescribed recommended dosage of the pain reliever as needed.

Name of minor: _____________________________ Relationship to you: _________________________

Reason for which release is intended: ____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.
Signature of Parent or Guardian ___________________________________ Date: __________________

Print name of Parent or Guardian ____