



Medical and Health Insurance Form

Name _____

Medical History

Please indicate the childhood illnesses your student has had and complete the information about your child's current physical condition. If your student has not had that illness or condition, please check the "No" box.

Childhood illness

	Yes	No	Date
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	
Measles	<input type="checkbox"/>	<input type="checkbox"/>	
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	

Current physical conditions

	Yes	No	Date
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding/Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Defect/Disease	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Vision Impairment	<input type="checkbox"/>	<input type="checkbox"/>	

Allergies

	Yes	No	Date
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Insect Sting Reaction	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	
Poison Ivy, etc.	<input type="checkbox"/>	<input type="checkbox"/>	

Food Allergies (Please list)

Medication Allergies (Please list)

Other Allergies (Please list)

Health Information (Please attach additional paper if necessary)

Has the student been under any medical care within the past three months? If so, explain.

Explain any treatment the student has received in the past for his/her physical, mental, or emotional health.

Is the student on a special diet? If so, explain.

Should the student be restricted in recreation or swimming? In what way?

Is there anything else we should know about your child, or any other special needs he or she may have?

Health Insurance Information

Name _____

My student has health insurance

Name of insurance carrier _____

Policy or group number _____

Name of policy owner (Insured) _____

In addition

I assume full responsibility for payment of medical expenses that are not covered by my insurance and are incurred as a result of my student's participation in the Explore Your Future program.

Parent/Guardian signature _____ Date _____

My student does not have health insurance

I assume full responsibility for payment of medical expenses incurred as a result of my student's participation in the Explore Your Future program.

Parent/Guardian signature _____ Date _____

In case of emergency

First contact name _____

Day phone: (_____) _____ Night phone: (_____) _____

Second contact name _____

Day phone: (_____) _____ Night phone: (_____) _____

Permission Slip and Consent for Medical Treatment (Parent/Guardian)

This health history is correct as far as I know. I give permission for the above named student to participate in all prescribed program activities except as noted on Page 1 of this form.

I also give permission for _____ (print student's name) to be given first aid in case of emergency, while he/she is in attendance at the EYF program. This includes permission for the child to be taken to the emergency department of a local hospital if the injury is serious enough to require medical attention. I hereby waive and release all responsibilities and anyone involved in the EYF program of any liabilities or claims in association with anything that might occur while my child is attending the program. I verify all information I have provided to be true and correct.

Parent/Guardian's Name (Please print) _____

Parent/Guardian's Signature _____ Date _____