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| **MEDICAL FORM** **2019 SUMMER PROGRAMS** **Please Print**  Full Name Sex  Marital Status   Birth Date Phone  M D Y  Age Home Address  Box # or Street City State Zip Area Code  Name, Relationship of Next of Kin  Address  Box # or Street City State Zip  Next of Kin’s Phone Number Cell Day Night Area Code Area Code Area Code  Name, Address, & Phone of Family Physician    HEALTH INSURANCE INFORMATION REQUIRED  Name of Ins. Co. Subscribers ID No. Group No. Subscriber’s Name   Address of Ins. Co. CHECK NAME OF PROGRAM  Other (if not shown above) Basketball   Football   Tennis   Cheerleading   Debate   |
|  **AUTHORIZATION AND CONSENT** Please read and sign below. If the student is under the age of 18, a parent or guardian must also sign. I agree that the attending physician or whomever he or she may designate may evaluate and treat all injuries or illnesses for which help is sought. In the case of a minor student, (under the age of 18) this treatment may proceed without prior notification of the undersigned parent or guardian. I also agree that needed immunizations may be administered. I further agree that the Student Health Service may release any medical information to other health care providers who are involved in my care.  Signature of summer program participant * Signature of minor’s parent or guardian ***(required)***

 Date * **A minor in North Carolina is any person under the age of 18.**
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**PERSONAL HISTORY** *Comment on all positive answers below.*

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| ARE YOU ALLERGIC TO:  | Yes  |  | HAVE YOU HAD:  | Yes  |
| Penicillin  |   | Headaches  |   |
| Sulfonamides  |   | Migraines  |   |
| Foods-specify below  |   | Neurological disorder  |   |
| Bees, wasps  |   | Seizures  |   |
| Other medications  |   | Alcohol abuse problems  |   |
| Specify below  |   | Other drug use problems  |   |
| **Do you receive allergy injections?**  |   | Smoking/tobacco use  |   |
| HAVE YOU HAD:  | Yes  | Eating disorder  |   |
| Mononucleosis  |   | Depression  |   |
| Chickenpox  |   | Anxiety  |   |
| Hepatitis B  |   | ADD, ADHD  |   |
| Hepatitis C  |   | Diagnosed learning disorder  |   |
| HIV  |   | Other psychological disorder  |   |
| Tropical disease  |   | Cancer  |   |
| Specify:  |   | Chronic medical condition  |   |
| Hearing disabilities  |   | Specify:  |   |
| Vision problems  |   | Surgery or serious injury  |   |
| Corrective lenses  |   | Serious head injury  |   |
| Asthma  |   | Concussion  |   |
| Respiratory disorder  |   | Mobility disorder  |   |
| Heart disease  |   | Organ loss  |   |
| High blood pressure  |   | Victim of personal assault, rape  |   |
| Stomach or intestinal disorders  |   | **Current prescription medicines** – list  |
| Menstrual cycle disorders  |   |   |
| Kidney disease  |   |   |
| Sexually transmitted diseases  |   |   |
| Anemia  |   | **Current non-prescription medicines** – list  |
| Blood disorders  |   |   |
| Diabetes  |   |   |
| Thyroid disease  |   |   |
| Other endocrine disorders  |   |   |

Remarks or additional information:

TO PARTICIPANT, PARENT, OR GUARDIAN

Is this participant capable of carrying a full program of fitness activities, including sports of all kinds? Yes  No  If “No”, please state limitations below.

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| Is there anything else about this participant that we should know? Yes  No  If “Yes”, explain below.  |  |
| Is the participant now under treatment or medication for any medical or mental health condition? Yes  No   | If “Yes”, explain below.  |

Date Signed

*Student, Parent, or Guardian*

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| **VACCINE INFORMATION (Participates should document these immunizations)** **A. TETANUS–DIPHTHERIA: Dates of three most recent. One must be a Tdap given after May 2005.**  DTP  DTaP  Td  DTP  DTaP  Td  DTP  DTaP  Td  Tdap                         (MO) (DAY) (YR) (MO) (DAY) (YR) (MO) (DAY) (YR) (MO) (DAY) (YR) **B. MEASLES, MUMPS, RUBELLA (MMR): TWO doses required.** (MO) (DAY) (YR) Dose #1 – Immunization on or after 1st birthday . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Date of vaccination: Dose #2 – At least 30 days after 1st dose ....................................... Date of vaccination: (MO) (DAY) (YR) **Signature or Clinic Stamp Required:** Physician’s Name Phone No: ( ) Physician’s Signature Address:  |

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