

MEDICAL FORM
2009 SUMMER PROGRAMS
Please Print

Full Name _____ Age _____ Sex _____

Marital Status _____ Soc. Sec. _____ Birth Date _____
M | D | Y

Home Address _____ Phone _____
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 Day _____ Night _____
Area Code Area Code

Name, Address, & Phone of Family Physician _____

HEALTH INSURANCE INFORMATION REQUIRED

Name of Ins. Co. _____ Subscribers ID No. _____ Group No. _____

Address of Ins. Co. _____ Subscriber's Name _____

CHECK NAME OF PROGRAM

Basketball Football Tennis Cheerleading Debate

Other (if not shown above) _____

AUTHORIZATION AND CONSENT

I hereby agree that the attending physician or whomever he or she may designate may undertake treatment, including operations and/or the administration of necessary anesthesia, in serious or major illnesses or injuries without prior notification of the undersigned or any other person, and without obtaining consent of the undersigned or any other person, if in the judgment of the physician or designee it is necessary for health care reasons to proceed with the treatment without delay. I further agree that the attending physician or whomever he or she may designate may evaluate and treat all other injuries or illnesses for which help is sought. In the case of a minor individual (* under the age of 18), this treatment may proceed without prior notification of the undersigned parent or guardian, although every attempt will be made to notify the parent or guardian in the event of such an injury or illness. I also agree that needed immunizations may be administered. I further agree that any medical information may be released to other physicians who may be providing 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.**

Personal History – Comment on all positive answers under remarks.

Have you had?	Yes
Allergy to:	
Bees, wasps	
Peanuts	
Penicillin	
Sulfonamides	
Other (specify)	
Asthma	
Chicken pox/Varicella	
Diabetes, thyroid, endocrine problems	
High blood pressure	
Infectious mononucleosis	
Respiratory disorders	
Tropical disease (specify)	

Have you had?	Yes
Anemia	
Blood disorders	
Headaches	
Migraines	
Hearing disabilities	
Menstrual cycle disorders	
Stomach or intestinal disorders	
Smoking or other tobacco use	
Surgery or serious injury	
Current non-prescription medicines (list)	
Current prescription medicines (list)	
Current vitamins or supplements (list)	

Have you had?	Yes
Cancer	
Chronic medical condition (specify)	
Depression, anxiety	
Heart Disease	
Hepatitis B	
Hepatitis C	
Kidney disease	
Mobility disability	
Neurological disorder	
Other psychological problem	
Organ loss	
Seizure	
Serious head injury	
Vision problems, corrective lens	

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.

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 emotional condition? Yes No If "Yes", explain below.

Date _____ Signed _____
Student, Parent, or Guardian

IMMUNIZATIONS

A. Tetanus-Diphtheria

_ _	_ _	_ _
M D Y	M D Y	M D Y

 Booster (within 10 years)

_ _
M D Y

B. Measles, Mumps, Rubella (MMR) – 2 DOSES DOSE #1

_ _
M D Y

 DOSE #2

_ _
M D Y

OR Rubeola (Measles) – 2 DOSES DOSE #1

_ _
M D Y

 DOSE #2

_ _
M D Y

 or Positive Rubeola Titer

_ _
M D Y

Mumps – 2 DOSES DOSE #1

_ _
M D Y

 DOSE #2

_ _
M D Y

 or Positive Mumps Titer

_ _
M D Y

Rubella

_ _
M D Y

 or Positive Rubella Titer

_ _
M D Y

C. Polio series (if under 18 years of age) Yes No Booster (within 10 years)

_ _
M D Y

D. Hepatitis B DOSE #1

_ _
M D Y

 DOSE #2

_ _
M D Y

 DOSE #3

_ _
M D Y

E. Varicella DOSE #1

_ _
M D Y

 DOSE #2

_ _
M D Y

F. Meningococcal Polysaccharide (menomune) Conjugate (menactra) Date

_ _
M D Y

G. Quadrivalent Human Papillomavirus (HPV) DOSE #1

_ _
M D Y

 DOSE #2

_ _
M D Y

 DOSE #3

_ _
M D Y

H. _____
Physician, School or Public Health Clinic (Print Name) Physician Authorized Signature required Date

Telephone Number with Area Code Address