MEDICAL & EMERGENCY INFORMATION

This form must be completed, signed and turned in prior to the start of this program

Name _____ Birth Date _____ Sex_____

Address_____ City_____ State_____ ZIP _____

Is there a history of, or do you currently have. any physical limitations that might prevent you from fully participating in this program? Yes ____ No ____
If yes, please specify missing or injured body parts, weakness, eyeglasses, contacts, hearing aids, etc. _____
_____

Do you have any learning disability that might prevent you from fully participating in this program? Yes ____ No ____
If yes, please specify_____to help us with teaching.

Please check ( ) those that apply and provide necessary information on reverse side of this form.

Chronic Ailments:

_____ Asthma, or other respiratory problems

_____ Circulatory or heart problems

_____ Diabetes or hypoglycemia

_____ Epilepsy

_____ Hemophilia. or other bleeding problems

Allergies:

_____ Insect bites

_____ Bee stings

_____ Foods

_____ Drugs

_____ Others, if significant

Current medications or pertinent information _____

Blood type _____ Date of last tetanus shot _____

Family physician name _____ Phone _____

Most recent physical examination _____where are your medical records kept? _____

Insurance Carrier _____ Insurance ID # _____

Who should be notified in case of emergency?

Names _____ Relation _____

Phones _____(Residence) _____(Cell) _____ (Business

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any member of the medical staff or of a dentist licensed under the provisions of the Education Law and/or Public Health Law of the State of North Carolina and on the staff of any hospital holding a current operating certificate issued by the Department of Health of the State of North Carolina. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the above people prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if any of these people cannot be reached.

Signature _____ Date _____
Parent/Guardian