Health Form

Participant Information

Name

Date of Birth

Program

Program Dates

Contact Information

Emergency Contact #1

Emergency Phone #1

Emergency Contact #2

Emergency Phone #2

Physician's Name

Physician's Phone

Health History

Date of participant's last physical (must be within 13 months of the program start date):

Both myself and the physician above deem that the participant is in good health and able to participate in all program activities

Does the participant have any allergies, medical conditions or behaviorial concerns we should know about (diabetes, siezures, injuries, asthma, etc)?

Is the participant currently taking any medication?

YES ☐ NO ☐

Please List:

Has the participant had a concussion in the last 18 months?

YES ☐ NO ☐

What was the date?

Immunizations

I certify that the participant is up to date with all immunizations required by the state of to attend school: ☐

Please note: Immunization record must be uploaded by May 1

I hereby request exemption of the participant from the immunization requirements for program entry because all or some immunizations are contrary to my beliefs: ☐

Confirmation

☐ In case of emergency, I understand that every effort will be made to contact me. In the event I cannont be reached, I hereby give permission to the physician selected by the program director to secure and administer treatment, including, but not limited to, transport to emergency care, hospitalization, and adminstration of medications for the person named above. I further understand that if I do not have medical insurance that covers all costs, I will be responsible for such medical costs.

Main Contact: _____ Signature: _____

Date: _____