MEDICAL FORM
SUMMER PROGRAMS
Please Print

Full Name _____

Age _____ Sex _____ Marital Status _____ 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 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. _____

_____

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

NAME OF PROGRAM:

_____

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.**

PERSONAL HISTORY *Comment on all positive answers below.*

ARE YOU ALLERGIC TO:	Yes
Penicillin	
Sulfonamides	
Foods-specify below	
Bees, wasps	
Other medications	
Specify below	
Do you receive allergy injections?	
HAVE YOU HAD:	Yes
Mononucleosis	
Chickenpox	
Hepatitis B	
Hepatitis C	
HIV	
Tropical disease	
Specify:	
Hearing disabilities	
Vision problems	
Corrective lenses	
Asthma	
Respiratory disorder	
Heart disease	
High blood pressure	
Stomach or intestinal disorders	
Menstrual cycle disorders	
Kidney disease	
Sexually transmitted diseases	
Anemia	
Blood disorders	
Diabetes	
Thyroid disease	
Other endocrine disorders	

HAVE YOU HAD:	Yes
Headaches	
Migraines	
Neurological disorder	
Seizures	
Alcohol abuse problems	
Other drug use problems	
Smoking/tobacco use	
Eating disorder	
Depression	
Anxiety	
ADD, ADHD	
Diagnosed learning disorder	
Other psychological disorder	
Cancer	
Chronic medical condition	
Specify:	
Surgery or serious injury	
Serious head injury	
Concussion	
Mobility disorder	
Organ loss	
Victim of personal assault, rape	
Current prescription medicines – list	
Current non-prescription medicines – list	

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 mental health condition? Yes ☐ No ☐ If "Yes", explain below.

_____

Date _____ Signed _____

Student, Parent, or Guardian

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 (MO) (DAY) (YR)

☐ DTP ☐ DTaP ☐ Td (MO) (DAY) (YR)

☐ DTP ☐ DTaP ☐ Td (MO) (DAY) (YR)

☐ Tdap (MO) (DAY) (YR)

B. MEASLES, MUMPS, RUBELLA (MMR): TWO doses required.

Dose #1 – Immunization on or after 1st birthday . . . . . Date of vaccination: (MO) (DAY) (YR)

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: _____