

# MISSOURI YMCA YOUTH IN GOVERNMENT – 2009-2010 STUDENT MEDICAL FORM

|   |  |                       |
|---|--|-----------------------|
| <b>Student Information</b>  |  |                       |
| First:  | MI:  | Last:                 |
| DOB:     /     /  | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | School / Delegation:  |
| <b>Emergency Contact Information</b>  |  |                       |
| Name:   | Relationship:  |                       |
| Daytime Phone: (     )     -  | Evening Phone: (     )     -                               |                       |
| Name:   | Relationship:  |                       |
| Daytime Phone: (     )     -  | Evening Phone: (     )     -                               |                       |
| Name:   | Relationship:  |                       |
| Daytime Phone: (     )     -  | Evening Phone: (     )     -                               |                       |
| <b>Health History</b> <i>(Check if you have had any of the following)</i>   |  |                       |
| <b>Illnesses:</b> <input type="checkbox"/> Diabetes <input type="checkbox"/> Convulsions <input type="checkbox"/> Heart defect/disease <input type="checkbox"/> Ear infections <input type="checkbox"/> Bleeding/clotting disorder<br><b>Allergies:</b> <input type="checkbox"/> Hay fever <input type="checkbox"/> Insect stings <input type="checkbox"/> Ivy poisoning <input type="checkbox"/> Penicillin <input type="checkbox"/> Other drugs:<br><b>Diseases:</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Chicken pox <input type="checkbox"/> German measles <input type="checkbox"/> Measles <input type="checkbox"/> Mumps                                       |  |                       |
| List injuries and/or operations and dates (use back of form if necessary):  |  |                       |
| List any prescription medications and special dispensing needs(use back of form if necessary):  |  |                       |
| <b>Doctors &amp; Health Insurance</b>   |  |                       |
| Physician:  | Phone: (     )     -                                       |                       |
| Dentist:  | Phone: (     )     -                                       |                       |
| Does your family have medical / health insurance?   | <input type="checkbox"/> Yes <input type="checkbox"/> No   |                       |
| Carrier:  | Policy/Group #:  |                       |
| <b>Parent's / Guardian's Authorization</b>  |  |                       |
| YIG advisors have my permission to provide the following medication, or their generic equivalent, in accordance with the recommended dosage and intervals of administration, in the event I cannot be reached to administer this medication in a timely manner. Initial each to indicate approval.  |  |                       |
| _____ Regular Strength Tylenol  | _____ Benadryl   | _____ Pepto-Bismol    |
| _____ Aspirin   | _____ Advil  | _____ Calamine Lotion |
| This health history is correct, so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted by me. I hereby give permission to the physician selected by the acting director to order X-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the acting director to hospitalize, secure proper treatment for, and to order injection and or anesthesia and or surgery for my child as named above on this form. I understand that my insurance will cover this expense, or I will assume responsibility. |  |                       |

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Signature of Parent/Guardian Date