Medical Information Form

The information provided on this form will be held in the strictest confidence and will not be seen by any person or agency (excluding the instructors/staff) except in the event of a medical emergency. The forms must be completed for all children participating in a CCK weeklong lesson program. CCK will destroy the forms within one week from the end of the program.

Name of Child:________________________________ Date of Program:____________________

Gender: ☐ Male ☐ Female Age:__________ Date of Birth:________________________

Name of pediatrician:____

Address of pediatrician: ____

____

Phone # of pediatrician:____

Emergency contact #1:____

Relationship to child: ____

Emergency contact #1 phone #s: (H)________________(W)________________(C)______________

Emergency contact #2: ____

Relationship to child: ____

Emergency contact #2 phone #s: (H)________________(W)________________ (C)______________

Health Insurance Company:____

Health Insurance Group #:___________________________ Subscriber Name:____________________

Health Insurance Company Address:____

____

Health Insurance Company phone # ____

1. Does the program participant have any medical condition that would restrict your child's participation in the CCK program?

2. Please list all allergies your child has.

3. If your child is allergic to bee/insect stings, may a bee sting kit be used in case of anaphylactic shock?

4. Does your child have asthma? If so, how serious are the attacks that are triggered by exercise?

5. Does your child have any special dietary requirements?

6. Is your child susceptible to problems associated with excessive heat? Is yes, please describe these problems.

7. What was the date of your child's last tetanus shot?

I, the undersigned, do hereby authorize instructors/staff of CCK to contact directly the person(s) named on this form, and do authorize these officials to contact the named pediatrician(s) to render such treatment as may be deemed necessary in an emergency for the health of the child named on this form. In the event that physician(s) or other person(s) named on this form cannot be contacted, or if distance or circumstances make it impractical for such person(s) to render direct medical assistance, the instructors/staff are hereby authorized to take whatever action is deemed necessary in their judgment for the health of the child. This may include, but is not limited to, taking of the child to a hospital for treatment or making arrangements for the child to leave the program for the purpose of returning to their pediatrician(s) for treatment. In all such cases the child's parents/guardians/insurance company is financially responsible for all medical treatment and transportation made in order to receive medical treatment. This form will be kept confidential from all persons at all times except the program instructor who will hold this form. I understand that this form will be shared with appropriate medical personnel in case of any medical situation that requires medical treatment.

______________________________ Signature of Parent or Guardian

______________________________ Date of Signature