

Indicate health history information below. A check means yes. Please explain any checks in the space provided.

- | | |
|--|--|
| <input type="checkbox"/> Respiratory problems-Asthma, Tuberculosis, persistent cough, etc. | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Heart problems-high or low blood pressure, Rheumatic Fever, etc. | <input type="checkbox"/> Emotional or mental disorders |
| <input type="checkbox"/> Stomach or intestinal problems-ulcers, jaundice, hernia, colitis, indigestion, etc. | <input type="checkbox"/> Recent exposure to a contagious disease |
| <input type="checkbox"/> Eye, Ear, Nose, Throat-Hay fever, ear infections, impaired sight or hearing | <input type="checkbox"/> Currently under a doctor's care |
| <input type="checkbox"/> Nervous disorder-convulsions, epilepsy, dizziness, etc. | <input type="checkbox"/> Physical limitations |
| | <input type="checkbox"/> Kidney, gall bladder or liver disease |
| | <input type="checkbox"/> Diabetes or hypoglycemia |
| | <input type="checkbox"/> Muscular/Skeletal-arthritis, recent fractures |

Approximate date of last physical: _____

Please explain any checks: _____

RECOMMENDATIONS AND RESTRICTIONS

Any treatment at present time? _____

Any medication needed by the member should be administered before or after the Summer Specials. If this is not possible, a parent/guardian must bring and administer the medication. _____

Is there any other information that staff need to know about your child? _____

List any special accommodations that are needed in order to participate in the program: _____

PARENTAL AUTHORIZATION FOR EMERGENCY MEDICAL CARE
MUST BE SIGNED BY PARENT/GUARDIAN

If medical information changes I agree to notify the Extension Office. I hereby authorize you, in the event of an emergency, that is, when you are unable to reach me for authorization or when circumstances require immediate action, to proceed according to good medical practice with treatment of my daughter/son. Also, I authorize the hospital attending physician, or other health care specialist administering the treatment to release pertinent information to the insurance company assuming coverage for the same.

Parent's/Guardian's Signature

Date

Insurance Company Name: _____ Policy Number: _____

Insurance Company Address _____

Insurance Company Phone Number: _____ Subscriber Name: _____