Emergency Medical Information Form

Please complete a form for EACH child you are registering.

PARTICIPANT’S NAME: ____________________________________________

DOES PARTICIPANT HAVE/HAS PARTICIPANT EVER HAD (IF YES, EXPLAIN):

ALLERGIES:
   YES___ NO___ EXPLAIN: _______________________________________

HEART CONDITION:
   YES___ NO___ EXPLAIN: _______________________________________

DIABETES:
   YES___ NO___ EXPLAIN: _______________________________________

HEARING IMPAIRMENT/HEARING AIDS:
   YES___ NO___ EXPLAIN: _______________________________________

VISION IMPAIRMENT/GLASSES OR CONTACTS:
   YES___ NO___ EXPLAIN: _______________________________________

OTHER:
   YES___ NO___ EXPLAIN: _______________________________________

IS PARTICIPANT SUBJECT TO (IF YES, EXPLAIN):

HEADACHES:
   YES___ NO___ EXPLAIN: _______________________________________

SEIZURES:
   YES___ NO___ EXPLAIN: _______________________________________

MOTION SICKNESS:
   YES___ NO___ EXPLAIN: _______________________________________

FAINTING:
   YES___ NO___ EXPLAIN: _______________________________________

SLEEP WALKING:
   YES___ NO___ EXPLAIN: _______________________________________

UPSET STOMACH:
   YES___ NO___ EXPLAIN: _______________________________________

OTHER:
   YES___ NO___ EXPLAIN: _______________________________________

DOES PARTICIPANT HAVE AN ALLERGIC REACTION TO (IF YES, EXPLAIN):

BEE STINGS:
   YES___ NO___ EXPLAIN: _______________________________________

PENICILLIN:
   YES___ NO___ EXPLAIN: _______________________________________

POISON IVY/OAK/SUMAC:
   YES___ NO___ EXPLAIN: _______________________________________

LATEX:
   YES___ NO___ EXPLAIN: _______________________________________
Does your child have any environmental allergies?

YES___ NO___ IF YES, EXPLAIN: ____________________________________________________________

Does your child have any food allergies?

YES___ NO___ IF YES, EXPLAIN: ____________________________________________________________

Does your child have any other allergies not already described above?

YES___ NO___ EXPLAIN: _________________________________________________________________

Has the participant had any serious illness or surgery within the past ten years?

YES___ NO___ EXPLAIN: _________________________________________________________________

Does the participant have any condition that would prevent him/her from participating in any activities?

YES___ NO___ EXPLAIN: _________________________________________________________________

Does the participant take any prescription medication?

YES___ NO___ EXPLAIN: _________________________________________________________________

Are any drugs ineffective in treatment?

YES___ NO___ EXPLAIN: _________________________________________________________________

Please list any other condition that the supervisors should know about to help avoid or handle any medical situation that might arise:

________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

Participant’s blood type:_______________________________________________________________

Please note that a current tetanus shot is required for participation.
Date of last Tetanus shot:_______________________________________________________________