



PARENT INFORMATION

Parent's name: _____

Address: _____

Telephone: _____

Medical History and Release

Please check any that apply to participant:

- | | |
|--|--|
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bee Sting allergy | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Penicillin allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other (specify on separate sheet) |

Date of last tetanus booster: _____

Current prescribed medication: _____

Any other medical condition the leaders should be aware of: _____

Health Insurance Information

Insurance Company: _____

Identification/Policy Number: _____

Family Physician's Name and Phone Number: _____
