

Medical History Form

This information is confidential and will only be shared with District Six employees who have a legitimate need to know, per HIPAA guidelines.

MEDICAL HISTORY:

Date of Last Tetanus shot _____

Please list any hospitalizations and/or surgeries: _____

Does your child have a serious medical condition? Yes No

Please describe: _____

List all medications your child is currently taking:

Name of Medicine	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Will your child need these medications while on this overnight trip? Yes No

Are there Emergency Medications your child will need access to while on these trips? (ex.: EpiPen, Glucagon, Inhalers)

I authorize the band nurse or District Six representative to administer these medications while on overnight trips. Yes No

Please list all allergies: (medications, food, insects, etc.):

Allergen	Reaction	Treatments
_____	_____	_____
_____	_____	_____

Is there any information about your child's physical or mental health that we need to know including:

- | | | | |
|---|---------------------------------------|--|-------------|
| <input type="checkbox"/> Sun poisoning | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Strains | Other _____ |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Asthma | <input type="checkbox"/> Weak Ankles/knees | _____ |
| <input type="checkbox"/> Sunburn | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Rashes | _____ |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Menstrual Cramps | _____ |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Sprains | <input type="checkbox"/> Leg Pains | _____ |
| <input type="checkbox"/> Stomach upsets | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | _____ |

The following medications will be available for your child if needed. Please check with your child's physician to question any interactions these medications may have with medicine your child may currently be taking. **PLACE A CHECK** by the medicines you give permission for your child to take (Please note: if these medications need to be administered to your child for a time period that exceeds 24 hours, you will be notified.)

- | | | | |
|---|-----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Advil | <input type="checkbox"/> Tums | <input type="checkbox"/> Benadryl | <input type="checkbox"/> Chloraseptic |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Immodium | <input type="checkbox"/> Eye Drops | <input type="checkbox"/> Cough Drops |
| <input type="checkbox"/> Caladryl Clear | <input type="checkbox"/> Orajel | <input type="checkbox"/> Insect Sting Gel | |

In case of medical emergency, I hereby give permission to the physician/hospital selected by the nurse or organization director to hospitalize, secure proper treatment for, and/or order injections, anesthesia or surgery for any child, as named above, and the undersigned will be responsible for any medical bills or hospital expenses incurred. I certify that all the above information is accurate and complete. This authorization is to be effective for this school year only.

Custodial Parent/Guardian Signature _____ Date: _____

In Witness Whereof, I have hereunto set my hand and affixed my official seal this _____ day of _____, 20 ____
State of South Carolina County of _____
Notary's Signature and Seal _____
My Commission Expires _____
Witness _____