Emergency Medical Information Form

Please complete so that health providers can be aware of your personal health needs.

Name of Participant: Grade:

Does participant have: (If “yes” explain)

___Yes ___No ALLERGIES?_____
___Yes ___No HEART CONDITION?_____
___Yes ___No OTHER?_____

Is participant subject to: (If “yes” explain)

___Yes ___No HEADACHES?_____
___Yes ___No SEIZURES?_____
___Yes ___No MOTION SICKNESS?_____
___Yes ___No FAINTING?_____
___Yes ___No SLEEP WALKING?_____
___Yes ___No UPSET STOMACH?_____
___Yes ___No OTHER?_____

Does participant have a reaction to: (If “yes” explain)

___Yes ___No PENICILLIN?_____
___Yes ___No OTHER DRUGS?_____
___Yes ___No POISON IVY, OAK, SUMAC?_____
___Yes ___No OTHER?_____

___Yes ___No Has the participant had any serious illness or surgery within the past ten years?
Please list:_____

___Yes ___No Has the participant ever been stung by a bee?_____

___Yes ___No Did the participant have an allergic reaction?_____

Parent(s) Signature _____ Date _____

Phone Numbers: Home: Other: _____

Primary Contact Email Address: