

Participant Health Form

This form should be completed in full. It should enable your child to receive treatment if taken to the hospital by school personnel or a sponsor. One form should be completed for each child. PLEASE COMPLETE ALL SECTIONS!

I, the undersigned, do hereby authorize officials and sponsors of the _____ to contact directly the person named on this document, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event physicians, other persons named on this form, or parents cannot be contacted, the school officials are hereby authorized to take whatever actions is deemed necessary in their judgment, for the health of aforesaid child. I will not hold the school financially responsible for emergency care and/or treatment for said child.

Full Name of Child	
Home Address	Area Code and Phone Number
City, State, Zip Code	
Social Security Number	Date of Birth

Name of Parent, Guardian, or Grandparent or other relative who can be reached if necessary	Area Code and Phone Number
Name of Parent, Guardian, or Grandparent or other relative who can be reached if necessary	Area Code and Phone Number

Known medical problems:
Allergies:
Prescription and over-the-counter medicines used:
Child's private physician and phone number:
Insurance information:
Party responsible for payment:

Parent or Guardian Signature

Date

