Medical and Emergency Information Form

This form must be completed, signed and turned in with your registration.

Do you have a history of or do you currently have, any physical limitations that might prevent you from fully participating in this course? Yes_____ No _____

If yes, please specify missing or injured body parts, weakness, eyeglasses, contacts, hearing aids, etc.

Do you have any learning differences that might prevent you from fully participating in this course? Yes _____ No ______ (If yes, please specify)

Please check all those that apply and provide necessary information on reverse side of this form.

Chronic Ailments:

- ☐ Asthma, or other respiratory problems Circulatory or heart problems
- ☐ Diabetes or hypoglycemia
- ☐ Epilepsy
- ☐ Hemophilia or other bleeding problems Allergies:
- ☐ Insect bites
- ☐ Bee stings
- ☐ Foods Drugs
- ☐ Others, if significant

Current medications or pertinent information:

- Blood Type: ____
- Date of Last Tetanus Shot: ____

Family Physician Name: ____

Physician's Phone Number: ____
Date of most recent physical examination: _____________________________________

Medical Insurance Provider: ____

Phone Number: ____

Who should be notified in case of emergency?

Name: ____

Phone: ____

Alternate Emergency Contact: ____

Phone: ____

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any member of the medical staff or of a dentist licensed under the provisions of the Education Law and/or Public Health Law of the State of Florida, and on the staff of any hospital holding a current operating certificate issued by the Department of Health of the State of Florida.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

It is understood that effort shall be made to contact the above people prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if any of these people cannot be reached.

Name: (please print): ____
Parent/Guardian

Signature: ____

Date: ____