Confidential Medical Record

PART 1 General Information

Child's Name _____ Birth date _____
Height _____ Weight _____ Age _____
Mother/Guardian's name _____Tel. # _____
Address _____City _____ State _____ Zip_____
Email _____
Father/other Guardian's name _____ Tel. #_____
Address _____City _____ State _____Zip _____
Email _____

In case of emergency :
First contact: _____Relationship _____
Home Phone ( )_____ Business Phone ( ) _____
Alternate contact: _____ Relationship _____
Home Phone ( )_____ Business Phone ( )_____

Family Physician _____ Phone ( ) _____

Insurance: Each family is responsible for their child's medical expenses. Sickness and accident insurance is recommended but <u>not</u> required.
Insurance company name _____ Policy Number _____
Address _____City _____ State _____ Zip _____
Is pre-authorization required? _____ If yes, phone ( ) _____

PART 2 Medical Information

All information is kept confidential and is meant to help us provide a supportive and safe atmosphere for everyone involved in the program.

Allergies/Intolerance to any insects, plants, foods, medications, etc. - List below. Please describe your child's reactions (if you know them) to any of the above.

Does your child take any kind of medication? ☐yes ☐no If so, what and since when?

Do you understand that in order to administer prescription drugs to your child, we require the original labeled bottle or written directions from a doctor? ☐yes ☐no

What conditions are the above medications required for? Is your child experiencing any side effects?

Describe your child's current physical exercise activity. Include frequency, duration and intensity.

Answer "yes" or "no" below, for your child

	Yes	No
a. Seizure within past year	___	___
b. Hospitalization within past 2 years	___	___
c. Emergency Dept. visit within past year	___	___
d. Neck, back, shoulder, knee, ankle pain or injury	___	___
e. Medical equipment needed	___	___
f. Other medical issues, illnesses or symptoms	___	___

Give details on any question for which you checked "yes". Include symptoms and/or any restrictions.

Does your child have any mental, emotional or psychological issues we should be aware of at this time?

What is the date of your child's last tetanus shot? _____

PART 3 Signature required for emergency treatment

I, _____ (print name), hereby give consent for emergency treatment and/or hospitalization for my child if it becomes necessary as a result of participation in Red Earth. The information provided above is a complete and accurate statement of the physical and psychological factors, which may affect my child's participation in this program. I realize that failure to disclose such information could result in serious harm to my child and/or fellow participants. I agree notify Red Earth should there be any change in my child's health status prior to the start of or during the program.

Parent / Guardian _____ Date _____