SuperKids Training and Mentoring Program

Medical History and Consent Form 2014

Child's Name			(*First Name*)			(*Last Name*)			
Date of Birth		Age		Sex					
Home Address									
City, State, Zip Country									
Phone			Grade in 2014-15 (fall)						
Birth Marks/Scars		Weight		Height		Eye Color		Hair color	
Ethnicity	☐ African/American ☐ Asian/Pacific Islander ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Others								

Parent/Guardian Information

Parent/Guardian Name:		**Parent/Guardian Name:**	
Address:	_____	Address:	_____
Work phone:	_____	Work phone:	_____
Mobile Phone:	_____	Mobile Phone:	_____
Home Phone:	_____	Home Phone:	_____
Employer:	_____	Employer:	_____
Occupation:	_____	Occupation:	_____
Email:	_____	Email:	_____
Email:		Email:	

Emergency Contacts who are authorized to pick up STAMP Participants

In the case of emergency, we will contact the participant's parent or guardian first. In the event a parent or guardian cannot be reached, we may need to contact at least two other friends or relatives. Only adults listed on this form will be able to pick up your child/children. Photo ID required for pick up.

Name:		Name:	
Address:		Address:	
Relationship:		Relationship:	
Mobile Phone:		Mobile Phone:	
Alternate Phone:		Alternate Phone:	
Email:		Email:	
Email:		Email:	

Medical Caregivers (Information required by state law)			
Family Doctor/ Medical Provider: Address: Phone: Email: Preferred Hospital:	_____ _____ _____ _____ _____ _____	Family Dentist: Address: Phone: Email:	_____ _____ _____ _____ _____

Medical History	
Diseases Give approximate dates	Asthma_____ Shortness of Breath_____ Seizures_____ Diabetes_____ Hypertension_____ Bleeding/Clotting Disorders_____ Blood disorder_____ Heart Defect/Disease_____ Convulsions _____ Hernia _____ Kidney Disease _____ Tuberculosis_____ Pains_____ Skeletal Issues _____ Scoliosis _____ Meningitis _____ Scarlet Fever _____ German Measles_____ Measles_____ Mumps_____ Chicken Pox_____ Tuberculosis_____ Mononucleosis_____ Rubella _____ Ear Infection _____ Hearing Issues_____ Eye Disorders_____ ADD/ADHD_____ Autism _____ Aspergers_____ Developmental Delays or Accommodations: _____ Disability or chronic or recurring illness: _____ List operations, serious injuries, or restriction of physical activity: _____ Has your child required psychiatric counseling or hospitalization? If yes, please. explain: _____ Anything not listed above: _____

Allergies Give approximate dates	Hay Fever _____ Insect Sting_____ Poison Ivy/Oak Poisoning etc._____ Penicillin_____ Pollen_____ Foods_____ Synthetics_____ Medications _____ List other Allergies here: _____
Dietary Restrictions	List here : _____

Medical Treatment Authorization *(prescription and over-the-counter products)*

If your child is currently taking medications, please complete this section. This includes over-the-counter and prescription medications. For your child's protection, we cannot allow staff to administer medication without this form. All medications sent to the STAMP must be in the original container with dosage directions and/or doctors instructions clearly labeled on package. Dosages will be administered and documented according to directions on the package unless a physician directs otherwise.

Medical Condition:	Medication: _____ Amount to be given: _____ When: _____ Comments or Instructions: _____ Parent/Guardian Signature: _____ Date: _____
	Has your child **required** medication during the past six months? ☐ Yes ☐ No If yes, please explain: _____
	Please indicate which , if any, of the following may needed to be given to your child at STAMP: ☐ Acetaminophen ☐ Ibuprophen ☐ Sudaphene ☐ Benedryl ☐ Calamine ☐ Bacitracin ☐ Antacid ☐ Insect Repellent ☐ Sunscreen ☐ Throat Lozenges ☐ Any other, pls. list _____

Medical Release	This Health History is correct so far as I know, and the child/teen herein described has permission to engage in all STAMP activities, expect as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the STAMP director to order X-rays, routine tests, treatment and necessary transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the STAMP director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photo-copied for trips out of STAMP campus. **Signature of parent or guardian** _____ **Date:**_____

Health Insurance Information

Child's name as it appears on Insurance Policy: _____

Medical Insurance Company: _____ Group Number: _____

Policy Number: _____

Name of Insurance Policy Holder: _____

Name of Person responsible for child's medical care: _____

All STAMP participants must have health/hospitalization insurance. Whether submitting an insurance card for permanent or temporary insurance, be sure the coverage period includes the STAMP session you selected.

Please scan and email a copy of your child's insurance card with this form.

PHYSICIAN'S EXAMINATION FORM: ***This section has to be completed by a physician /medical provider.***

Name of the Child :_____ **Date of Birth:**_____

Date of most recent physical examination: _____

IMMUNIZATION:	**DATE:**	**IMMUNIZATION:**	**DATE:**
Polio Vaccine (TOPV or e-IPV)		Rotavirus	
MMR (combined) Mumps, Measles, Rubella		Varicella	
Hepatitis B (Hep B)		Hepatitis A (Hep A)	
DTP (Diphtheria, Tetanus, Pertussis)		Pneumococcal Conjugate Vaccine (PCV or Prevnar)	
Meningococcal conjugate vaccine (MCV4 or Menactra)		Tetanus and diphtheria toxoids/tetanus and diphtheria toxoids and acellular pertussis vaccine (Td/Tdap)	
Haemophilus influenza			

Healthcare Recommendations by Physician/Medical Provider

In my opinion, [child's name] _____ is able ___ is not able ___ to participate in an active youth program, including martial arts. If exercise should be restricted, please list why:

_____

_____

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____ Blood Type:_____

Physical Development: _____

The applicant is under the care of a physician for the following condition(s):

_____

Current treatment (include current medications):

_____

Explanation of any loss of consciousness, convulsion or concussion:

_____

Does child have epilepsy/seizures? ☐Yes ☐ No Does child have diabetes? ☐ Yes ☐ No

Additional Health Information: _____

Physician's Signature: _____**Date:** _____ **Phone No:** _____

Physician's Address: _____