BGSU
Bowling Green State University

MEDICAL HISTORY AND CONSENT FOR EMERGENCY MEDICAL TREATMENT

Directions: Parents/Guardians of minors must complete this form for program staff to provide routine health care and seek emergency medical treatment. Please answer all questions.

PARTICIPANT INFORMATION

Participant's Name_____Gender_____
Home Address_____Date of Birth_____Age_____
City/State/Zip_____Home Phone_____
Name of Program Attending _____From ___/___/___ To ___/___/____
Overnight ☐ Yes ☐ No

EMERGENCY NOTIFICATION (PARENT OR GUARDIAN)

Before a participant under 18 years of age can be treated, the law requires us to obtain parent/guardian consent for treatment. Accordingly, for the safety and well-being of the participant, please provide us with as many phone numbers as possible.

PRIMARY CONTACT
Name
Relationship
Phone #1
Phone #2

SECONDARY CONTACT
Name
Relationship
Phone #1
Phone #2

PHYSICIAN INFORMATION
Family Physician
Address
Phone
DENTIST INFORMATION
Family Dentist
Address
Phone

SPECIALIST INFORMATION
Specialist Name
Address
Phone
SPORTS CAMPS ONLY:
Date of last physical examination / /
Sport or activity cleared for:
List Any Restrictions

MEDICAL HISTORY - Please indicate if the participant has any chronic childhood conditions or diseases related to the following and list details, including any activity restrictions in the space provided.

- ☐ Arthristis & Rhematologic Conditions
- ☐ Asthma
- ☐ Bones & Muscles
- ☐ Brain & Nervous System
- ☐ Cancer & Tumors
- ☐ Digestive System
- ☐ Ears, Nose, Throat/Speech, &Hearing
- ☐ Endocrine Glands, Growth & Diabetes
- ☐ Genetic, Chromosomal & Metabolic Conditions
- ☐ Heart & Blood Vessels
- ☐ Kidney & Urinary System
- ☐ Learning Disorders
- ☐ Lungs & Respiratory System
- ☐ Sexual & Reproductive System
- ☐ Skin Disorders
- ☐ Sleep Disorders

Details:_____
_____
_____

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Partcipant's Name_____

ALLERGIES - ☐ this person has no allergies OR ☐ this person has allergies as noted below

TYPE (INSECT, FOOD, MEDICATIONS)	DESCRIBE REACTION

[ ] This person carries an EpiPen

MEDICATIONS - ☐ this person takes NO medications OR ☐ this person takes medications as noted below

MEDICATIONS	DOSAGE	FREQUENCY	DIAGNOSIS

Note: Our program staff is unable to administer any medications, prescription or non-prescription, to participants without a signed Permission to Dispense Medication by Camp Program Staff form

DISABILITY - Please indicate if participant is handicapped or disabled in any way: ☐ Psychological ☐ Neurological ☐ Hearing ☐ Pulmonary ☐ Learning ☐ Mobility ☐ Other_____

CURRENT MEDICAL CONDITIONS - Please indicate if participant currently has any medical conditions or limitations that do not constitute a handicap or a disability that would impair or limit the participant from fully engaging in the activities of the camp for which the participant is registering, and provide a complete description of such conditions or limitations:_____

_____

MEDICAL INSURANCE INFORMATION

Please provide a copy of the front and back of insurance card OR complete the information below

Name of Policyholder _____
Policyholder ID # _____
Medical Insurer Name _____
Group Name _____
Group ID # _____

IMMUNIZATIONS

The particpant has been immunized in accordance with the recommended immunization schedules for children and adolescents approved by the CDC and The American Academy of Pediatrics ☐ Yes ☐ No.

CONSENT FOR MEDICAL TREATMENT

In the event reasonable attempts to contact me are unsuccessful, **PERMISSION** is hereby granted for the examination, treatment and medical care of the participant by Falcon Health/Wood County Hospital or another duly licensed healthcare facility. **PERMISSION** is also granted to execute on behalf of the participant any admission or consent forms needed to obtain such treatment. By signing below, I agree that I have read the foregoing and consent to the terms and conditions as stated.

Signature of Parent/Guardian **Print Name** **Date**

STAFF USE:
Form Complete ☐ Yes ☐ No Reviewed by: Action Needed: