MEDICAL INFORMATION

IN CASE OF EMERGENCY NOTIFY:

Name ____
First Middle Last

Relationship to Participant ____

Home Address ____
Street City State Zip

Business Telephone (____) ____________________ Home Telephone (____) _______________________

Name ____
First Middle Last

Relationship to Participant ____

Home Address ____
Street City State Zip

Business Telephone (____) ____________________ Home Telephone (____) _______________________

MEDICAL INSURANCE:

Insurance Company ____

Policyholder ____________________________________ Employer ______________________________

Policy # _________________________________ Subscriber # __________________________________

Pharmacy Card ____

CONSENT FOR EMERGENCY MEDICAL CARE

In the event medical treatment is needed and Parent/Guardian is not available to make decisions or arrangements for such medical care for _______________________________________, I authorize the staff of Mountain Meadow Youth Ranch to provide or arrange for medical care at their discretion.

____ ___________________________
Parent/Guardian Signature Date

____ ___________________________
Parent/Guardian Signature Date

MOUNTAIN MEADOW STUDENT MEDICAL HISTORY

Student Name: ____________________________________ Date: ________________________

1. Physician's name, address, and telephone number:

____

____

2. Please list any current or previous health problems affecting student:

____

____

____

3. Does the student wear glasses or contacts? ________

   Date of last eye exam: ____________________________

   Optometrist's name, address and telephone number:

____

____

4. Does the student wear dentures? ________

5. Has the student ever been hospitalized? ________

   Reason: ____________________________________ Dates: _______________________

   Physician: _______________________________ Hospital: ________________________

6. Has the student ever had surgery? ________

   Reason: ____________________________________ Dates: _______________________

   Physician: _______________________________ Hospital: ________________________

7. Has the student ever been involved in an accident? ________

   Injuries: ____

____

8. Has the student ever broken a bone? ________

   If so, which one(s): ____

____

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9. Is the student allergic to any of the following?

________ Penicillin ________ Aspirin

________ Sulfa ________ Bee or wasp sting

________ Hornet or other insect ________ Shellfish

________ Iodine ________ Other ______________________

________ Any other drugs: ____

If so, what are the reactions? ____

____

Other allergies/reactions/treatment (hives, hay fever, eczema, asthma, etc.):

____

____

10. Has the student experienced any of the following? ________

________ Bed wetting ________ Stuttering

________ Nail biting ________ Head banging

________ Nightmares ________ Tics

________ Other ____

If so, at what age? ____

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11. Please list any fears the student has had (darkness, thunder, death, etc.) and at what ages:

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12. Is the student currently on any medications? ________

Please list medications and dosage: ____

____

____

____

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13. Has the student had any of the following diseases, illnesses, medical problems or disorders?

_______ Anemia (low red blood count)
_______ Asthma
_______ Bladder or Kidney infection
_______ Bone condition
_______ Chicken Pox
_______ Convulsions or seizures
_______ Dermatitis, eczema
_______ Diabetes
_______ Epilepsy
_______ Frequent colds/sore throats
_______ Frequent ear infections
_______ German Measles (3 day)
_______ Heart disorder
_______ Hepatitis
_______ High blood pressure
_______ Meningitis, Encephalitis
_______ Mononucleosis
_______ Mumps
_______ Muscle Weakness
_______ Pneumonia, Bronchitis
_______ Polio
_______ Problems with constipation or diarrhea
_______ Red measles
_______ Rheumatic Fever
_______ Scarlet Fever
_______ Scoliosis
_______ Ulcers
_______ Venereal disease (herpes, gonorrhea, syphilis)
_______ Whooping Cough (croup)
_______ Other: ____

If so, please give dates: ____

____

____

Vaccine/Test if given as combinations (MMR or MR) enter date in each appropriate box.	Date (1st)	Date (2nd)	Date (3rd)	Date (4th)	Date (5th)
Polio (TOPV)					
DPT and/or TD (Diphtheria, Pertussis, Whooping cough and diphtheria only)					
Measles (Rubella – 10 day, red measles)					
Rubella (German Measles – 3 day measles)					
Mumps					
Tuberculosis skin test					
Tetanus					

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Please list any other pertinent medical information not previously listed and any other important information relating to the health history of the student or required limitations on activities at Mountain Meadow Youth Ranch.

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This form represents the complete medical history of the student.

____ _______________________
Parent/Guardian's Signature Date

____ _______________________
Parent/Guardian's Signature Date

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OTC MED SHEET

(Over The Counter Medication)

Parents: In order for us to provide OTC medication to your son, MMYR must have your approval. These medications may include, but are not limited to: Tylenol, Ibuprofen, Mucinex, Tylenol cough and cold, Nyquil, Sudafed, etc…

Parent Signature_____________________________Date_____________

Parent Signature_____________________________Date_____________

Medications you do not want your son to receive. Please list below.

____
____
____
____
____

Confidential Parent Insurance Information

This is a confidential form needed to submit insurance to doctors, dentists, physicians etc. When submitting insurance cards, it is now required to give the date of birth of both the insurance card holder and the insured. This information will only be given when required and will remain confidential. Thank you for understanding.

Card Holders Name:____

Social Security #:____

Date of Birth:____

If more than one insured

Card Holders Name:____

Social Security #:____

Date of Birth:____