MEDICAL HISTORY FORM

Goyan's Name (last, first):____
Youth Worker/Advisor Name:____
Date of Birth:________________________________Age:_________Grade (Fall 2008):___________
Address____
City:_____________________________________State:_____________ Zip:_____________________

Mother's Name____Cell #:_____________________
Father's Name____Cell#:_____________________
Physician's Name____ Phone:________________
Physician's address:____
Hospital of Choice: ____ Tel#:__________________
Dentist's Name____ Tel#:__________________
Address:____
Any medical problems ?____
Is your child taking either prescription or over-the counter medication on a regular basis? Yes/ No
Name of drug/ dose/ time of day it is taken____
Physician prescribing drug: ____
Does child have any drug allergies? Yes / No
If yes, Name of Drug(s):____
Other Allergies:____
Type of Reaction (be specific):____
Comments:____

List names and telephone numbers of three persons to contact if your child is ill or injured. In the event that the parent or guardian cannot be contacted, these persons may have to make a medical decision.

1. Name________________________________Relationship_______________ phone______________
2. Name________________________________Relationship_______________ phone______________
3. Name________________________________Relationship_______________ phone______________

EMERGENCY MEDICAL TREATMENT

To the Advisors, Coaches and Clergy:

In the event that I am unable to be reached and my child needs EMERGENCY MEDICAL TREATMENT during any time he/she participates in GOYA, you have my permission, and I hereby designate you my agent, to act in my son's/daughter's best interest in obtaining necessary transportation and medical care until I can be contacted. I hereby release you from any claim arising out of your and the doctor's actions relating to my child's illness/injury, and I assume and agree to pay for any professional medical services and other fees/costs incurred.

Parent/Guardian Signature:____Date_________________

Permission for emergency medical treatment will be effective throughout the Goyan's enrollment. If there is any change of information, please contact either the Clergy or Advisors

Name of Insured:____
Insurance Company____
Group Identification # : _________________________________Member # _______________________
Telephone # ____
_____Attached is a copy(front and back) of the Insurance Card of the Insured-stapled to this form.