MASC/MAHS MEDICAL HEATH FORM

Please print or type:

Name: _____ Age:_____ Sex:_____

Address:_____

Street City Zip

Home Phone: (____)_____ Parent's name(s) _____

Parent's daytime phone(s): (_____)_____ (_____)_____

Name and phone number of additional persons to be contacted in case of emergency (other than parents):

_____ Phone: (____)_____

School I attend:_____ School phone: (_____)_____

School Address:_____

Street City Zip

School Principal: _____

Who is responsible for medical payments? ___ Individual ____ Insurance

Medical Insurance Company Name: _____

Address:_____

Policy Number:_____

Physician's Name:_____ Phone Number: (____)_____

BRIEF MEDICAL HISTORY

Special Health Concerns (allergies, etc.)_____

Current Medications:_____ Dosage per day:_____

Asthma: ___ Yes ____ No Medication:_____

Diabetes: ___ Yes ____ No Medication:_____

Epilepsy: ___ Yes ____ No Medication:_____

Should the delegate be restricted from any type of activity? _____ Yes _____ No

If yes, please explain:_____

Are there any prescription or non-prescription drugs that should NOT be administered? ____No _____Yes,

Which ones?_____

Allergic to any medication? ___YES ____ NO (if yes, please list) _____

A licensed health care provider may provide my child with: ___ Tylenol ___ Advil ____ Neither

NOTE: *IF YOU ARE TAKING MEDICATION REGULARLY, PLEASE BRING A SUPPLY IN A LABELED CONTAINER.*

I, the parent or legal guardian of _____(my child), authorize the Michigan Association of Student Councils & Honor Societies to obtain medical care for my child in the event such care is necessary. I understand that, if possible, I will be contacted in the event my child requires medical attention. I grant to a license health care provider or accredited hospital permission to perform any medical and/or surgical procedures that are essential for the treatment of my child and agree to be responsible for payment for such care. I release MAHS, MASC, its employees, and agents from any damages, liability, or loss resulting from their securing in good faith medical care for my child.

Signed: _____

(Parent or guardian) (Date)

Parent/Guardian Name – PLEASE PRINT: _____