

TREATMENT AUTHORIZATION and MEDICAL INFORMATION

(Please print neatly and completely)

Name: _____ Birth Date _____ / _____ / _____
(Last) (First) (Initial) (Month) (Day) (Year)

Home Address _____
(Street) (City) (State) (County) (Zip Code)

Home Phone #: () _____ Cell Phone # () _____

Father's Name _____ Home Phone() _____ Office () _____

Mother's Name _____ Home Phone() _____ Office () _____

Physician's Name _____ Phone() _____

Office Address: _____

Alternative person to notify in case of emergency if parents/guardians are not available.

Name _____ Phone() _____
(Last) (First) (Relationship)

Year of Last Tetanus Shot: _____ *(If it has been more than 5 years, we suggest that you get a booster shot)*

Have you had or been vaccinated for: **Measles?** Yes / No **Chicken Pox?** Yes / No **Hepatitis?** Yes / No

Any reaction to penicillin?	Yes	No	Any reaction to any other drugs?	Yes	No
Any regular use of medication?	Yes	No	Any use of insulin?	Yes	No
Any chronic physical problems?	Yes	No	Any known allergies (food/medicine)?	Yes	No
Any dietary restrictions?	Yes	No			

Special Medical Problems: (Circle all that apply) Diabetes Asthma Heart Conditions Hypoglycemia Arthritis
 Seizures Mono High Blood Pressure Rheumatic Fever TB Breathing Disorders Migraine Headaches
 Carpal Tunnel Syndrome Back Problems Bleeding Disorder Wear Glasses/Contacts
 Knee/Ankle Injuries Any Fractures/Surgeries (location) _____
 Other (please describe below)

If you answered YES to any of the above items, please explain:

Non-Prescription Medication: Circle those Over-the-Counter Medications you **do not** give permission for staff to administer:

Aspirin Tylenol Advil Ibuprofen Antacids Cough Cold & Sinus Cold & Flu Antidiarrheal

Allergic Reaction Laxative Topical Ointments, Creams, Lotions.

If you have a preference or special need for a specific Over-the-Counter medication, it is your responsibility to supply the corps with that medication.

(Continued on page 2)

