Mount Sterling Community Center
164 East Main Street
Mt. Sterling, Ohio 43143
Phone: (740) 869-2453
www.mountsterlingcc.org

Emergency Authorization Medical Form

Personal Information of Center Participant:

Full Name:____**Date of Birth**_______________

Home Address: ____

City____ZIP______________________

Height:_______________ Weight:______________Male:_________Female________

Parent/Guardian #1:

Name, relationship to Center participant:____

Phone: Day:__________________________Evening:_______________________________

Emergency Contact #1 ***(other than Parent/Guardian listed previously):***

Name, relationship to Center participant:____

Phone: Day:__________________________Evening:_______________________________

Health Care Information:

Name, relationship to Center participant:____

Phone: Day:__________________________Evening:_______________________________

HEALTH HISTORY

The following information must be filled in by the Center participant's legal guardian:

Please notify Mt. Sterling Community Center of any changes to this form that may occur.

ALLERGIES: ***(List all known. Describe reaction and management of the reaction.)***

Medication allergies *(list):*____

Food allergies *(list):*____

Other allergies *(list) – include insect stings, hay fever, asthma, animal dander, etc.:*___________________________________

____

MEDICATIONS BEING TAKEN: please list ALL medication (including over-the-counter or nonprescription drugs) taken routinely.

Center participant takes NO regular medication *initial here:*__________

Center participant takes medications as follows *initial here:*__________

Med#1_________________Dosage_________Specific times taken each day_______ Reason for taking____
Med#2_________________Dosage_________Specific times taken each day_______ Reason for taking____
Med#3_________________Dosage_________Specific times taken each day_______ Reason for taking____

<u>Please Complete Form on Back of Page</u>

(continued)

RESTRICTIONS

Dietary: please describe any dietary restrictions____
Explain any restrictions to activity *(e.g. any limitations what adaptations are necessary):*_________________________
____

General Questions

	Has/does the Center participant: *(Explain "yes" answers below)*	*(circle one)* YES	NO
1	Had any recent injury, illness or infectious disease?	yes	no
2	Have a chronic or recurring illness/condition?	yes	no
3	Ever been hospitalized?	yes	no
4	Ever had surgery?	yes	no
5	Have frequent headaches?	yes	no
6	Ever had a head injury?	yes	no
7	Ever been knocked unconscious?	yes	no
8	Wear glasses or protective eyewear?	yes	no
9	Ever had frequent ear infections?	yes	no
10	Ever passed out during or after exercise?	yes	no
11	Ever had seizures?	yes	no
12	Ever had high blood pressure?	yes	no
13	Ever been diagnosed with a heart murmur?	yes	no
14	Have any skin problems (e.g. itching, rash, acne)?	yes	no
15	Have diabetes?	yes	no
16	Have asthma?	yes	no
17	Had mononucleosis in the past 12 months?	yes	no
18	Had problems with diarrhea/constipation?	yes	no

Please explain any "yes" answers, noting the number of the questions_______________________________
____

Anything else we should know?____
____

I certify that all the above information is true to the best of my knowledge.

____
Signature of Parent/Guardian of Center Participant Date

As a parent or legal guardian of the above-named Center participant, I hereby give my consent for emergency medical care prescribed by a duly licensed doctor of medicine or doctor of dentistry. This care may be given under whatever conditions are necessary to preserve life, limb, or wellbeing of my dependent. I understand that expenses incurred in obtaining emergency medical treatment are my responsibility.

____
Signature of Parent/Guardian of Center Participant Date