# SGSC Medical Information Form and Authorization for Medical

**I.** ***Basic Personal Information*** (please print) **Today's Date:____/____/______**

**Child's Name:__________________________________________ Age: _______________**

**Local Address: _____________________________________________________________________________**

**City:_____________________________________State:______________________Zip:_________________**

**Cell Phone Number:________________________Work Phone Number: ___________________________**

**Home Phone Number: ______________________**

**Height: ___________________________ Weight: __________________________**

***II. Emergency Contact Information***

**Person to notify in case of emergency:__________________________Relationship:__________________**

**Contact's Phone Number(s): (____)________________________, (____)___________________________**

**Contact's Address:** _______________________________________________________________________

**City:_____________________________________State:______________________Zip:________________**

**Family Physician:_______________________________Phone Number: (____)_____________________**

**Insurance Provider:________________________________Phone Number: (____)___________________**

**Policy Number: __________________________________________________________________________**

(Note: The institution does not offer any form of health, liability, or other types of insurance for participants. Please attach a copy of the front and back of your insurance card with this form.)

***III. Medical Information***

**Please list any current medical concerns or medical history we need to know about your child: (Ex. past injuries, current conditions, physical limitations, etc.)___________________________________________**

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**List any allergies your child has (Ex. medications, stings, food, iodine, latex, etc.)**

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**List any medications your child is currently taking, their purpose, dosage, and times taken:**

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**Does your child need any accommodations to safely participate in the program? If yes, please explain.**

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**Does your child require any assistance with his or her medications? If so, please explain:**

______________________________________________________________________________

______________________________________________________________________________

***IV. Authorization for Medical Care***

I understand that my child is voluntarily participating in a_ (institution)_ program. By signing this form I hereby acknowledge that all information is accurate and current, that any activity restrictions, allergies, and medications are listed on this form, and to the best of my knowledge, my child is capable of participating safely in the program. I acknowledge that my failure to disclose relevant information may result in harm to my child and/or others during this program. I agree to notify the program of any changes in my child's mental, physical, or medical condition before the program begins.

I understand that __ (institution)________does NOT provide medical insurance for my child and that I should consult my child's physician before allowing my child to participate in this program. In the case of accident or illness, I hereby authorize the program staff to administer or seek medical treatment for my child, as they see fit, including routine first aid care or emergency medical treatment. I hold harmless and agree to indemnify the program,__ (institution)________, and the Board of Regents from any claims, causes of action, damages, and/or liabilities arising out of or resulting from said medical treatment. I acknowledge that I am solely responsible for any hospital or other costs arising out of any bodily injury or property damage sustained through my child's participation in such voluntary program.

**Name of Participant:_________________________________________Date:______/______/_______**

**Signature of Parent or Guardian: _____________________________________________________**

**Parent or Guardian Name:___________________________________________________________**

**Work Phone:________________________________Cell Phone: _____________________________**