

MEDICAL HISTORY FORM

All GOYANS, Youth Workers, Advisors, and all adults attending events must fill out this form.

Goyan's Name (last, first): _____

Youth Worker/Advisor Name: _____

Date of Birth: _____ Age: _____ Grade (Fall 2009): _____

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#: _____

Dentist's 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