YOUTH PURSUIT OF EXCELLENCE

MEDICAL INFORMATION Date: _____

Name		Date of Birth
Parents'/Guardians' Names	Phone (home/work/cell) Dad	Phone (home/work/cell) Mom
Medical Insurance #	Alternate Emergency Contact Name / Phone	

Are there any prolonged health conditions and/or disabilities that we should be aware of?
(e.g., bedwetting, homesickness, medical history, surgical, dental, emotional behaviors etc…?)

Immunizations (Diptheria Tetanus Measles ,mumps, rubella Hepatits B, Other)

◯ Up to date ◯ Not applicable _____

Allergies (to medications, food, insects, etc.) Please include the nature of the reaction to the allergen.

1. Life-threatening/ Anaphylactic reaction Yes ◯ No ◯
2. Life-threatening/ Anaphylactic reaction Yes ◯ No ◯

Dietary Needs (including vegetarian, no dairy, etc.)

I understand that in the event of an illness or injury requiring medical treatment for my child, Excellence Seminars International staff will attempt to contact me or my alternate before treatment is administered, unless the illness/injury is of such minor extent that only minimal first aid treatment or non-prescription medication (e.g., Tylenol, antihistamine) is required.

I, parent/guardian of _____ hereby authorize the Program Leader or first aid attendant to make such decisions regarding treatment and to direct such treatment as described above. Further, in the event that I cannot be reached in a reasonable amount of time, I authorize the Excellence Seminars International Staff or first aid attendant to obtain from the local medical clinic or district hospital, or to provide on site the necessary medical attention for the complete health and such treatment as described above.

Parent/Guardian Signature _____