# Student
Medical History Form

Full Name: _____ Date of Birth:

Parent(s) Name(s): _____ Gender: Male Female

Phone Number(s): _____

If you cannot be reached,
who can we contact in an emergency: _____

## Medical Waiver

I verify that the medical information on my child is complete and accurate and that I have legal custody of the participant named above. I grant my permission for adult leaders at the District Event to administer general first aid treatment for any minor injuries or illnesses experienced by my child. In the event of an emergency, I hereby authorize the calling of an ambulance and/or physician at my expense to provide whatever emergency medical or surgical treatment is deemed necessary by a licensed physician.

I authorize release to the insurance company listed any information needed to process a claim. I understand that I am financially responsible for all charges incurred.

Parent Signature _____

## Current Medications

Please list any medications you are currently taking:

_____

_____

## Allergies

Do you have any allergies?
Please list them below.

_____

_____

## Insurance Information

Insurance Provider:

Policy Number:

Group Number:

Patient Signature _____ Date