

EMERGENCY MEDICAL FORM

Community Bicycle Center

Health History and Examination Form for Youth

Information on this form is gathered to assist us in identifying appropriate care.

Name: _____ Birthdate _____ Sex _____ Age _____
Last First MI.

Parent/Guardian: _____

Home _____ Phone # _____
Street & Number City State Zip

Cell phone # _____

Second Parent/Guardian or Emergency Contact: _____

Home _____ Phone # _____
Street & Number City State Zip

Cell Phone # _____

Health History:

(Check & Give approx. dates)

Diseases

Allergies (dates not needed)

_____ Frequent ear infections
_____ Heart Defect/Disease
_____ Convulsions
_____ Diabetes
_____ Bleeding/Clotting Disorders
_____ Hypertension
_____ Mononucleosis

_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps

_____ Hay Fever
_____ Ivy Poisoning, etc.
_____ Insect Stings
_____ Penicillin
_____ Other Drugs
_____ Asthma
_____ Others (*specify*)

Operations or serious injury (*dates*) _____

Chronic or recurring illness or medical condition _____

Dietary restrictions _____

Current medications (*parent/guardian needs to bring meds in original container with instructions*) _____

Any physical or emotional challenges that may interfere with activity? _____

Name of Family Physician _____ Phone #: _____

Name of Dentist/Orthodontist _____ Phone #: _____

Do you carry family medical/hospital insurance? YES / NO

If so, indicate: Carrier _____ Policy or Group # _____

***MUST BE COMPLETED FOR ATTENDANCE**

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel to order X-rays, routine tests, treatment to release any records necessary for insurance purposes and to provide or arrange necessary related transportation for me/or my child/ward. In the event I cannot be reached in an emergency, I hereby give permission to the physician to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent/guardian _____ Date: _____