



PLEASE BE ADVISED BY SIGNING THIS, YOU ARE ACKNOWLEDGING THE INFO BELOW IS TRUE AND UP TO DATE. IT IS YOUR RESPONSIBILITY TO ADVISE ASC OF ANY CHANGES TO YOUR CHILDS HEALTH FORM AND IT MUST BE RESUBMITTED AS NEEDED, ON THIS FORM ONLY.

(ASC) Non-profit 501 (c) (3) ID # 26-3032468

ASC Participant Medical Information Please print all information clearly.

Full Name: _____ Date of Birth: _____

Parent Name: _____ Parent's Phone: _____

Child's Pediatrician's Name: _____ Phone: _____

Date of last physical: _____ Date of last tetanus shot: _____

Insurance Company: _____

Member Number: _____

Medical Conditions: _____

List of past medical treatments: _____

List all current medications regardless of whether it needs to be taken or not: _____

Will your child need to take any prescription medications while staying with us? YES / NO If yes, please write directions on paper. Place directions and medication(s) in Ziploc bag with child's name on it. Allergies: (Please put N/A if your child does not any)

Food: _____

Medication: _____

Insect: _____

Other: _____

Does your child require an Epi-pen? YES / NO If yes, you must provide us with an Epi-pen to be kept on site during your child's stay. Epi-pen must be accompanied with a current prescription and doctors note. Specific Activities to be restricted for health purposes:

In an emergency situation, if for any reason we cannot get ahold of you, please provide us with someone else to contact: Name: _____

Phone Number: _____ Relationship to child: _____

Parent/ Legal Guardian (Print Name)

DATE

Parent/ Legal Guardian Signature