Connors State College Medical History Form

HEALTH HISTORY and PERMISSION FOR EMERGENCY MEDICAL CARE

Participants name: _____ DOB _____

( ) boy ( ) girl Home phone/contact number ( ) _____

Parent/guardian: _____ cell # ( )_____

Address:_____

Insurance Company and Policy number: _____

Does the student have any health problems such as, Asthma, allergies, diabetes, epilepsy, seizures, heart problems, vision, hearing problems, physical disabilities, etc _____

Behavioral Problems: _____

If yes, Give Details

_____

_____

_____

Does student take medication on a regular basis _____

If yes, Please list medicines and
dosages_____

_____

IN CASE OF SUDDEN ILLNESS OR ACCIDENT REQUIRING MORE ATTENTION THAN THAT OF NORMAL FIRST AID, I AUTHORIZE DR. STUART WOODS, THE EMT ON STAFF OR A DESIGNATED ASSISTANT TO TAKE MY CHILD TO A PHYSICIAN OR EMERGENCY CARE FACILITY AT HIS DISCRETION AND AUTHORIZE THAT PHYSICIAN OR EMERGENCY CARE FACILITY TO PERFORMANY TREATMENT DEEMED NECESSARY AND IN THE BEST INTEREST OF MY CHILD!

Signature of Parent/Guardian: _____

E-mail address (please print) _____