

IC Imagine Adventure Club Medical Form

for the period August 1, 2016 thru July 31, 2017

STUDENT NAME _____ DATE OF BIRTH _____
PARENT/GUARDIAN NAME _____ EMERGENCY PHONE _____

WORK PHONE _____
IN CASE OF EMERGENCY CONTACT _____ PHONE _____
FAMILY DOCTOR _____ OFFICE PHONE _____
MEDICAL INSURANCE PLAN # _____

A. Please note any concerns you have which would limit the student's full participation in bike club.

B. Are student's immunization shots are current (i.e. tetanus) YES NO

C. Student is subject to:

asthma sensitive skin sleepwalking nosebleed
 fainting sinus trouble convulsions high blood pressure
 tonsillitis frequent colds headache motion sickness
 bronchitis allergies (describe)

D. If you checked any of the above, please give more details (i.e. allergic to bees but does not need epi pen)

E. Medications – please list any taken on a daily bases and the purpose of each

F. Medications – please list any you take only if necessary (i.e. asthma inhaler)

I agree to update this form should changes arise in my child's health/medical condition.

PARENT/GUARDIAN SIGNATURE _____ DATE _____