CAS-CIAC Student Medical Form

Last Name: _____ **First Name:** _____

Street Address: _____ **City:** _____

Telephone: (H) (_____) _____-_____ (C) (_____) _____-_____

Sex: F M **Date of Birth:** _____ **Age:** _____
M/D/Y

Name of Parent/Legal Guardian: _____

Mother Telephone: (H) (_____) _____-_____ (W) (_____) _____-_____ (C) (_____) _____-_____

Father Telephone: (H) (_____) _____-_____ (W) (_____) _____-_____ (C) (_____) _____-_____

Emergency Contact (other than Parent/Guardian) **Name:** _____

Emergency Contact Telephone: (_____) _____-_____ **Relation to the Student:** _____

Family Physician: _____ **Telephone:** (_____) _____-_____

Insurance Company: _____ **Group Plan Number:** _____

Policy Number: _____ **Insurance Benefit Code:** _____

Does the student have any special physical needs? Y N (If yes, please explain.)

_____

Is the student allergic to any drugs? Y N If yes, please list: _____

_____

Is the student allergic to bee stings? Y N If yes, can student take antihistamines? Y N

Is the student currently under medical treatment? Y N (If, yes, please explain.) _____

_____

Please list all medications (including inhalers) the student is currently taking. _____

_____

Please list any operations within the last year. _____

Emotional Problems (hyperventilation, hysteria, depression, etc.) _____

_____

"I hereby give permission for the above named student to be treated by a physician or licensed nurse at a hospital or on the scene in the event of a medical or surgical emergency."

_____

Signature of Parent/Legal Guardian **Date**

Please make 2 copies. Turn one in at conference registration; retain one for school use.