Health History & Emergency Information

Institute for Creativity, Arts, and Technology at Virginia Tech

INSTRUCTIONS: Please provide detailed health information for determining appropriate supervision, support, and accommodations for the activity or event listed. **A parent or guardian must sign.** If the participant is a person with a disability and desires any assistive devices, services or other accommodations to participate in this activity, please contact the event director. **PLEASE PRINT ALL INFORMATION.**

NAME OF EVENT: _____
DATE(S) OF EVENT: _____ LOCATION: _____

PARTICIPANT IDENTIFICATION
NAME: _____
NAME YOU WISH TO BE CALLED: _____ Gender: _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ AGE: _____ BIRTHDATE: _____
RACE/ETHNICITY: (Optional) ☐ White ☐ Hispanic ☐ Black ☐ American Indian ☐ Asian ☐ Multicultural
PARTICIPANT CELLPHONE: _____ HOME PHONE: _____
HOME EMAIL: _____

PARENT / GUARDIAN IDENTIFICATION (Place a check beside who to reach in the event of an emergency.)
☐ PARENT/GUARDIAN 1 NAME: _____RELATIONSHIP: _____
EMAIL: _____ PHONE DAYTIME: _____
EVENING: _____ CELL: _____
☐ PARENT/GUARDIAN 2 NAME: _____RELATIONSHIP: _____
EMAIL: _____ PHONE DAYTIME: _____
EVENING: _____ CELL: _____
WHO HAS PRIMARY CUSTODY OF THE PARTICIPANT? _____
ADDRESS, IF DIFFERENT THAN CHILD: _____

EMERGENCY CONTACT INFORMATION (Parts 1 and 2 should be completed)
1. WHERE CAN YOU BE REACHED IN THE EVENT OF AN EMERGENCY?
LOCATION:_____ PHONE: _____
CELL PHONE: _____

2. IF YOU **CANNOT** BE REACHED, WHO SHOULD BE NOTIFIED?
NAME: _____ HOME PHONE: _____
WORK PHONE: _____ CELL PHONE: _____

RELEASE AUTHORIZATION
I give permission to the following individual(s) to pick up my child at the conclusion of this event:
Name(s): _____

Sign below at time of pick up (Receiving person must be pre-listed above):
Name (print): _____ Signature: _____ Date: _____

PHYSICIAN / INSURANCE INFORMATION
FAMILY PHYSICIAN NAME: _____ PHONE: _____
DENTIST / ORTHODONTIST NAME: _____ PHONE: _____

IMMUNIZATION HISTORY (This must be completed)
Are your child's immunizations up to date? ☐ YES ☐ NO
Most recent tetanus shot: (month/year) _____/_____

PARTICIPANT HEALTH AND MEDICAL HISTORY

1. Has the participant ever experienced (or had special needs in) any of the following? [Check (✔) all that apply]

- ☐ Asthma
- ☐ Eating disorders
- ☐ Diabetes
- ☐ Fainting spells
- ☐ Bleeding disorders
- ☐ Seizures/Convulsions
- ☐ Non-food allergies
- ☐ Attention disorders (ADHD)
- ☐ Wears contacts
- ☐ Behavior
- ☐ Other: _____

Please describe any condition or need that you checked: _____

_____

_____

2. Is the participant experiencing any current health problems, under medical care, receiving mental or behavioral services, or currently taking medication?

☐ YES ☐ NO If YES, *please explain:* _____

3. Has the participant undergone surgery, or experienced any injury, illness, allergy, or change in health status any time during the last year? Is there any reason that participation in a program or activity should be restricted?

☐ YES ☐ NO If YES, *please explain:* _____

_____

4. What else should we know about your child?

Programs include very rewarding, but sometimes challenging situations. Please inform us of any concerns that may arise related to your child's physical, mental, emotional, and/or social health in order that we may better provide appropriate supervision and support. _____

_____

DO YOU CARRY FAMILY MEDICAL / HOSPITAL INSURANCE?: ☐ YES ☐ NO (Check **√** one)

CARRIER: _____ POLICY ID #: _____

APPROVAL / EMERGENCY AUTHORIZATION

If this section is not signed, participation in the event/activity will not be allowed. You must contact your event director if there is a change in health status after submitting this form.

1. I give my permission for the participant named on this form to attend the program.
2. I hereby give permission to the medical staff person selected by the event/activity director to order X-rays, routine tests and treatment for my child (or for myself if I am a participant over 18 years old) as medically necessary. I also give permission for the participant to receive over- the-counter medication as needed under the guidance of the medical staff person. I understand that all attempts will be made to notify parents/guardians of any serious injury or illness to their child. If I cannot be reached in an emergency, I hereby give permission to the medical staff person to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/ or the participant named on this form. This form may be photocopied for use outside of the event/activity location.

ADULT PRINTED NAME: _____

SIGNED: **X**_____ Date: _____

(Parent / Legal Guardian or participant over 18 years old)

I understand and agree to abide with any restrictions placed on my activities according to this form.

YOUTH PRINTED NAME: _____

SIGNED: **X**_____ Date: _____

(Participant under 18 years old)