Medical History Name _____

Allergies:

Please indicate any allergies and the reaction your child had:

		Type	Reaction
Drug	No / Yes	_____	_____
		_____	_____
		_____	_____
Food	No / Yes	_____	_____
		_____	_____
Tape	No / Yes	_____	_____
Latex	No / Yes	_____	_____
Bee Stings	No / Yes	_____	_____

If yes, how do you treat the bee sting:

_____

Any food restrictions?

No / Yes - specify _____

_____

Medications:

Medication	Dose	How Often	Reason for Taking

Please mark any that apply:

Stomach Problems
( ) None
( ) Frequent nausea
( ) Nausea before performance
( ) Heartburn
( ) Severe menstrual cramps
( ) Frequent abdominal pain
( ) Constipation
( ) Diarrhea
( ) Other

Heart Problems
( ) None
( ) Yes - specify_____

_____

Head Problems
( ) None
( ) Frequent headaches
( ) Migraines
( ) Seizures
( ) Other_____

Skin Problems
( ) None
( ) Yes - specify _____

_____

Joint / Extremity Problems
( ) None
( ) Yes - specify _____

_____

Breathing Problems
( ) None
( ) Asthma
( ) Lung Disease
( ) Sinus problems
( ) Nose bleeds
( ) Other _____

Kidney Problems
( ) None
( ) Yes - specify _____

_____

Other Health Concerns
( ) None
( ) Yes - specify _____

_____

Diabetic
( ) No ( ) Yes - controlled with: ( ) Diet ( ) Pills ( ) Insulin

Comments or concerns about your child: _____

_____

Charisma Medical and Liability Release Form

Last Name: _____ First Name: _____ Middle Initial:_____

Date of Birth: _____ Parent/Guardian Names: _____

Address: _____ Home Phone: _____

_____ Cell Phone:_____

Emergency contact if unable to reach parents/guardian:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Family Physician: _____ Phone: _____

Insurance Company: _____Group Number: _____

Hospital Preference: _____

I/We, _____,(Parents/Guardian) give permission for any and all medical attention to be administered to our child_____ in the event of accident, injury, sickness, etc., under the direction of Northrop Charisma First Aid personnel, until such time as we may be contacted. I/We authorize payment of treatment, either personally or through personal health insurance of all costs incurred.

Parent/Guardian Signature _____ Date _____

I/We give permission for my child to receive over the counter medication, according to label directions, while participating in Charisma activities by First Aid personnel. Please mark below the medications permitted:

( ) Tylenol	( ) Midol	( ) Antibiotic Ointment	( ) Visine Eye Drops
( ) Aleve	( ) Tums	( ) Cough Drops	( ) _____
( ) Ibuprofen	( ) Peptobismal	( ) Throat Lozenges	

Parent/Guardian Signature _____ Date _____

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