WCSU 2017 *Summer SOAK* - Medical Report Form
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To Parent(s)/Guardian(s): **Complete Sections A – D** on page 1 then give pages 1 and 2 to your child's health-care provider for review, completion and signature. **All forms must be completed, signed & returned before a spot in the program can be guaranteed.**

SECTION A – STUDENT INFORMATION

Student Name: _____ _____ _____ DOB: _____ ☐Male ☐ Female
First Middle Last

Age: _____ Grade Entering: _____

SECTION B – MEDICAL HISTORY

Current/Chronic Health Conditions (seizures, diabetes, allergies, asthma, etc.):

Mental Health/Psychosocial Needs: (ADHD, anxiety, special needs or accommodations)

Allergies: ☐ No known allergies ☐ to foods _____ dietary restrictions yes ☐ no ☐
☐ to medication _____ ☐ environmental (insect stings, hay fever)_____
Describe previous reactions: _____ Epi-pen required ☐ yes ☐ no

Medication: ☐ No daily medications. ☐ Will take the following prescribed medication while at camp: **(include name, dose, frequency)**

If medicines must be taken during the summer program hours, school policy requires that medication be brought to the school by a parent/guardian in the **original pharmacy containers,** with a **health care provider's order** and a **written parent request.** Students are **not** allowed to carry medication with them while in school.

SECTION C – PERMISSION FOR TREATMENT

Permission for Treatment
I give permission for my child's physician, _____, to release information regarding medications and health concerns to WCSU SOAK Program health coordinator regarding my child, _____.

In the event of a serious accident or illness, I hereby authorize WCSU to contact my child's physician and/or to seek emergency medical care including transportation to a medical facility. I hereby authorize the physician and emergency room staff to administer care that is deemed necessary. I understand every effort will be made to contact family first.

_____ _____
Parent/Guardian Signature **Date**

SECTION D – HEALTH INSURANCE

Health/Insurance: Is student covered by health insurance ☐ yes ☐ no

If yes, Insurance Company:_____ Policy Number: _____

Subscriber: _____ Insurance company phone number:

_____

Dentist (if any): _____ Dentist phone number: _____

******Please notify us if there are any changes******

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To Medical Provider: Please review the health history information on page 1 provided by parent(s)/guardian(s) and complete the following section on this form.

Student's Name: _____

Relevant Medical Information

Date of last physical exam: _____ **Date of last Tetanus booster:** _____

Allergies: _____ **EpiPen Necessary:** Yes ☐ No ☐

Asthma: Yes ☐ No ☐ Emergency Medications: _____

Diabetes: Yes ☐ No ☐ Emergency Medications: _____

Seizure Disorder: Yes ☐ No ☐ Emergency Medications: _____

Clearance

This student is: ☐ Cleared without restriction

☐ Cleared, **with restrictions:**

_____

_____

☐ **Not cleared**

Reason: _____

_____

I have reviewed the student health history information and certify the above-named individual is able to participate **as indicated** in the above-named program based on physical examination within 12 months prior to start of the program date.

_____ _____

Name of Health Care Provider **Date**

_____ _____

Provider Signature **Telephone Number**