

WCSU 2018 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: _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
First	Middle	Last	
Age: _____		Grade Entering: _____	

SECTION B – MEDICAL HISTORY

<u>Current/Chronic Health Conditions</u> (seizures, diabetes, allergies, asthma, etc.): _____
<u>Mental Health/Psychosocial Needs:</u> (ADHD, anxiety, special needs or accommodations) _____
<u>Allergies:</u> <input type="checkbox"/> No known allergies <input type="checkbox"/> to foods _____ dietary restrictions yes <input type="checkbox"/> no <input type="checkbox"/> <input type="checkbox"/> to medication _____ <input type="checkbox"/> environmental (insect stings, hay fever) _____ Describe previous reactions: _____ Epi-pen required <input type="checkbox"/> yes <input type="checkbox"/> no
<u>Medication:</u> <input type="checkbox"/> No daily medications. <input type="checkbox"/> 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 <input type="checkbox"/> yes <input type="checkbox"/> 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******

