

## YOUTH'S HEALTH INFORMATION

If you are a youth below age 18, please fill out the insurance information below and return this form with your application.

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Should \_\_\_\_\_ (Name of registrant) be stricken in any way, accident or otherwise, and in the opinion of the counselor in charge, should emergency treatment be required, you have my permission to seek medical help, including surgery, which in your judgment is necessary during the MD State Trapping School, September 11, 12, 13, 2009.

A. The youth named above   IS     IS NOT   covered under hospitalization insurance with \_\_\_\_\_ Insurance Company, policy no. \_\_\_\_\_ in the name of \_\_\_\_\_.

The youth named above   DOES     DOES NOT   have an insurance card.

B. In case we are unable to contact you in an emergency, whom should we contact next?

Name \_\_\_\_\_

Phone \_\_\_\_\_

C. Family Physician: Dr. \_\_\_\_\_

Office Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

D. Does the youth have any allergies to medications, foods, insect stings, etc. ?

\_\_\_\_\_  
\_\_\_\_\_

E. Does he/she take any medications routinely? If yes, list names of medications, strengths, dosage schedule.

\_\_\_\_\_

F. Date of last Tetanus shot: \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_