

MEDICAL INFORMATION FORM

The information on this form is required for the safety of the participants in Quiet Waters Outreach's activities. All information disclosed in this form will remain strictly confidential.

GENERAL GUEST INFORMATION

Guest First/Last Name: _____ Sex: ___ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Guardian Name: _____

Guardian Address (if different): _____

City: _____ State: _____ Zip: _____ Guardian Phone: _____

Guest/Guardian Email: _____ Guardian Alternative Phone: _____

EMERGENCY CONTACTS

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

DISABILITY

Diagnosis (including any mental illness): _____

ALLERGIES (Please include any known allergies to food, insects, animals, plants, drugs, etc.)

List all allergies: _____

Describe reaction: _____

Describe treatment: _____

SEIZURES

Is guest affected by seizures? Yes No Describe type: _____

Are seizures presently controlled by medication? Yes No Date of last seizure: _____

MEDICATIONS

Please list ALL current medications/vitamins, prescription or nonprescription. Attach MAR or additional sheet if necessary.

1. Name: _____ Dosage: _____

When Taken: _____ Form: _____

2. Name: _____ Dosage: _____

When Taken: _____ Form: _____

3. Name: _____ Dosage: _____

When Taken: _____ Form: _____

4. Name: _____ Dosage: _____

When Taken: _____ Form: _____

Describe any recent medication changes: _____

(Please see reverse side)

MEDICAL HISTORY

Please indicate if any history of the following:

- | | | | |
|---|---|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Bleeding/Clotting Disorders | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Stomach Trouble | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Tubes in Ears | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Herpes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Ear Aches/Infections | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Feeding Tube | <input type="checkbox"/> TB | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Other communicable diseases: _____ | | | |

DIET RESTRICTIONS

Is the guest diabetic? Yes No Describe treatment: _____
 Other dietary restrictions: _____

PHYSICIANS

Doctor's Name: _____ Phone: _____
 Address: _____
 Dentist's Name: _____ Phone: _____
 Address: _____

INSURANCE INFORMATION

Is guest covered by medical insurance? Yes No
 Carrier: _____ Phone: _____
 Name of insured: _____ Relationship to guest: _____
 Social security number of policy holder or insurance ID number: _____

EMERGENCY AUTHORIZATION, LIABILITY, AND PUBLICITY RELEASE

I hereby give permission to the respite care provider to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for the guest named above. In the event I cannot be reached in an emergency, I hereby give permission to the respite care provider to secure and administer treatment, including hospitalization, for the person name above. This completed form may be photocopied as may be needed by the medical personnel. I hereby release the respite care provider from any and all liability of whatsoever nature and kind, and whatsoever occurring, relating to the medical care and/or administration and delivery of medication for the above for the person named above. Permission is hereby granted to allow photographs, videotapes and quotes to be taken for publishing and used to illustrate, promote, and advertise for Quiet Waters Outreach and its activities. This statement shall be valid unless revised or revoked in writing by the parent/guardian.

Signature of Parent/Guardian _____ Date _____

**** PLEASE INCLUDE PHYSICIAN'S ORDERS FOR ALL MEDICATIONS ****