



# СВЯТО ВЕСНИ ЗАХІД - 2011 HEALTH AND MEDICAL RECORD

To be filled out by parent, guardian, or adult participant. Please print in ink.

**Please attach a copy of the front and back of the insurance card.**

Name \_\_\_\_\_ PI.Kurin \_\_\_\_\_ PI.Stanytsia \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex \_\_\_\_\_

Name of parent or guardian \_\_\_\_\_ Telephone \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If person named above is not available in the event of an emergency, notify

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name of personal physician \_\_\_\_\_ Telephone \_\_\_\_\_

Personal health/accident insurance carrier \_\_\_\_\_ Policy No. \_\_\_\_\_

**ALLERGIES:** Food, medicines, insects, plants, others Yes No Explain: \_\_\_\_\_

## MEDICAL INFORMATION:

Circle all items that apply, **past or present**, to your health history.

ADHD (Attention-Deficit Hyperactivity Disorder) Convulsions/seizures Hemophilia Kidney disease

Asthma Diabetes High blood pressure Cancer/leukemia Heart trouble Other

Explain: \_\_\_\_\_

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used: \_\_\_\_\_

List any **medications to be taken at Sviato Vesny**, including drug, dosage, route (oral, injection, etc.), and frequency: \_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: \_\_\_\_\_

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: \_\_\_\_\_

## IMMUNIZATIONS: (Give date of last inoculation.)

Tetanus toxoid \_\_\_\_\_ Measles \_\_\_\_\_ Polio \_\_\_\_\_

DPT \_\_\_\_\_ MMR \_\_\_\_\_

Hepatitis A \_\_\_\_\_ Varicella \_\_\_\_\_ (or Chicken pox \_\_\_\_\_)

Hepatitis B \_\_\_\_\_

A medical evaluation (**physical examination**) conducted by licensed health-care practitioners is **required** if your **child** is currently **under medical care**, takes a **prescribed medication**, requires a **medically prescribed diet**, has had an **injury** or **illness during the past 6 months** that limited activity for a week or more, **has ever lost consciousness** during physical activity, or has **suffered a concussion from a head injury**.

I give permission for full participation in the Sviato Vesny Plast Program, subject to limitations noted herein. **In case of emergency**, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including, without limitation hospitalization, anesthesia, surgery, or injections or other administration of medication for my child (or for me, if participant is an adult). The health history provided to the best of my knowledge is correct.

Signature of parent/guardian or adult \_\_\_\_\_ Date \_\_\_\_\_