СВЯТО ВЕСНИ ЗАХІД - 2017
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_____ Pl.Kurin_____ Pl.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_____