

YOUTH SERVICES' PROGRAM MEDICAL FORM

Program Name: _____

Participant's Homeroom Teacher: _____

LAST NAME: _____ FIRST NAME: _____

SEX: M F AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____ PHONE: _____

Below is used for Youth Services statistic use only. All information is confidential

RACE/ETHNICITY: Caucasian ___ African American ___ Hispanic/Latino ___ Asian ___
Native American ___ Multicultural ___ Other ___

FAMILY MAKE UP: Two birth/adoptive parents ___ Step & birth parent ___
Single parent (female) ___ Single parent (male) ___ Grandparents ___ Relative/Guardian ___
DCF Guardianship ___ Foster parent(s) ___ On own ___

Medical Information:

PHYSICIAN: _____ PHONE: _____

DENTIST: _____ PHONE: _____

HEALTH INSURANCE NAME: _____

HOSPITAL PREFERENCE: _____

ASTHMA _____ GLASSES _____ CONTACTS _____ BRACES _____

MEDICATIONS TAKEN REGULARLY: _____

ANY ALLERGIES OR MEDICAL CONCERNS: _____

YEAR VACINATION LAST GIVEN: TETANUS _____ DIPHTHERIA _____ POLIO _____

PARENT/GUARDIAN NAME: _____ HOME# _____

WORK# _____ CELL# _____

Emergency Contacts (other than parent or guardian)

1.) NAME: _____ PHONE: _____ RELATIONSHIP: _____

2.) NAME: _____ PHONE: _____ RELATIONSHIP: _____

Activity Permission (mandatory)

I hereby give my permission for my child to participate in the above program through Ellington Youth Services.

SIGNATURE: _____ DATE: _____