Medical Information

Delegate's Name: _____ **Date of Birth**: _____

I hereby authorize the Family Exchange staff assigned to my child/teen to make arrangements for his/her welfare, including transportation in the event of an emergency, and for whatever emergency medical care may be deemed necessary for my child/teen's welfare.

In case of emergency notify: _____ Phone: _____

Relationship to Delegate: _____

Are you subject to any of the following: If YES, please explain the condition and/or frequency.

		Condition/Frequency
1.	Asthma/Respiratory Problems	Yes O No O _____
2.	Diabetes/Hypoglycemia	Yes O No O _____
3.	Heart Trouble	Yes O No O _____
4.	Lung Trouble	Yes O No O _____
5.	Fainting Spells	Yes O No O _____
6.	Convulsions	Yes O No O _____
7.	Epilepsy	Yes O No O _____
8.	Skin Disease	Yes O No O _____
9.	Kidney/Gallbladder/Liver Disease	Yes O No O _____
10.	Muscular/Skeletal Problem	Yes O No O _____
11.	Emotional or Mental Disorder	Yes O No O _____
12.	Stomach/Intestinal Problem	Yes O No O _____

Any Other Disorder (Please list & explain) _____

_____

FAMILY EXCHANGE

Do you have any allergies or reactions to drugs or non-drug items

Medicines:

1. Penicillin or Related Drugs: Yes O No O
2. Aminopyrine or Sulpyrine Type Drug: Yes O No O
3. Others: _____

Non-Drug Items:

Bees O Pollen O Dogs O Cats O Small Animals O

Food: _____

Do you have difficulties with any of the following:

1. Eyes Yes O No O _____
2. Uses Contact Lenses Yes O No O _____
3. Ears Yes O No O _____
4. Nose Yes O No O _____
5. Throat Yes O No O _____
6. Digestion Yes O No O _____
7. Sleepwalking Yes O No O _____
8. Bed-Wetting Yes O No O_____
9. Menstrual Problems Yes O No O _____

Any other Medical difficulties (Please list)_____

_____

Any surgical operations, accidents, or injuries, which required hospitalization in the past?

Yes O No O Explain:_____

Any recent exposure to a contagious disease?

Yes O No O Explain:_____

Will you be carrying any medicines/prescriptions? (Add a "P" for prescriptions)

Name of Medicine	Treats what Illness/Symptoms	Dosage/Times Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any physical activities that you are restricted from doing? If YES, please list.

Yes O No O Explain:_____

Any additional information Family Exchange should be aware of?

Yes O No O Explain:_____

Are you currently under a doctor's care?

Yes O No O Explain:_____

I Certify that all medical information has been included and that the above information is complete and accurate.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Date

FAMILY EXCHANGE