Youth Advisory Committee
Medical Form

Confidential medical history instructions

1. Complete this form thoroughly
2. Sign at the bottom of the second page
3. Attach a copy of your family's insurance card

Member general information (please print)

Name: ____ Age: __________

Home address: ____
(Number & Street) (City) (State) (Zip)

Home phone: (_____) ____________ Date of birth: __________ Sex: Male____ Female____

Family physician's name: ____

Address: ______________________________________ Phone: (_____) _____________
(Number & Street) (City)

Emergency contact general information (please print)

Name: ____

Home address: _________________________________ Home phone: (_____) __________
(Number & Street) (City)

Relationship: _____________________________ Business phone: (_____) ____________

Health insurance

Please furnish the following information about your family's health/hospitalization insurance.

Name of insurance company: ____

Address of insurance company: ____

Subscriber: ____

Certificate/Policy number: ____

Group number: ____

Health history (check if these apply to you or your child):

____ Rheumatic fever ____Asthma ____Epilepsy ____Convulsions ____ Diabetes ____

Other: ____

Allergies:

____ Aspirin ____ Penicillin ____ Bee Sting

____ Other drugs (list): ____

____ Food (list): ____

Precautions to observe: ____

Medications:

Drug	Purpose	Dosage
________________________	______________________	_____________________
________________________	______________________	_____________________
________________________	______________________	_____________________
________________________	______________________	_____________________

Medical treatment authorization

The [*Community Foundation*] must have permission to provide routine non-surgical medical care for participants/staff. Permission is also required to secure certain services which [*Community Foundation*] personnel are not equipped to perform. These services include x-rays, laboratory tests and emergency room services. Such services are readily available at nearby community hospitals.

The authorization is for the use of these services when deemed advisable by medical staff. In the event of any other routine medical problems, we will advise parent/guardian immediately.

Note: If under 18 years of age, the signature below must be of the parent or guardian. If over 18 years of age, the participant should sign for him/herself.

I HEREBY GIVE PERMISSION TO THE COUNCIL OF MICHIGAN FOUNDATIONS TO SECURE EMERGENCY MEDICAL AND SURGICAL TREATMENT AND ROUTINE NON-SURGICAL MEDICAL CARE FOR:

____

Print full name of participant

____ ______________________

Signature of participant or participant's parent/guardian Date