BEAR'S WEB MEDICAL FORM 2025

Participant/Staff Name: _____

DOB: _____ Current Age: ____

Gender at birth: _____ (for emergency only); Gender you align with if different (for respect): _____

Address: _____

City/State/Zip: _____

Contact Information

Primary Emergency Contact 1 name: _____

Address City/State/Zip: _____

Home phone: _____ Cell: _____

Primary Emergency Contact 2 name: _____

Address City/State/Zip: _____

Home phone: _____ Cell: _____

Immunization History

Date of last tetanus: _____ Permission to receive Tetanus if needed? _____yes _____no

Medication Information (for emergencies)

Currently on any medications?:_____yes _____no

Please list with dosages and timing: _____

_____

_____

_____

Allergies

Allergies to bees or other stinging insects: _____

What is your reaction? _____

Any other SERIOUS allergies: _____

Allergies to medication: _____

Do you carry an Epi-Pen? _____ Can you take Benadryl? _____

Name (participant): _____

Month/Year: _____

Insurance Information

Participant Name: _____ Primary Insured's name: _____ Date: _____

Address/City/State/Zip: _____

Personal Physician's name: _____ Phone: _____

Insurance Company Name: _____ Policy No. _____

Parent/Guardian or Student (if over 18) Signature: _____

Health History

Is there anything we need to know to assist you in the event of an emergency?

_____
_____
_____
_____

Is there anything the hospital or ER may need to know in the event of an emergency?

_____
_____
_____
_____

Permission

I give permission for _____ (participant/student name) to receive first aid and to be cared for as needed in the event of an emergency.

_____ _____

Signature Date

_____ _____

Printed Name Date

_____ _____

Full name of student Date