*Delta Sigma Theta Sorority, Inc. ~ Tempe Alumnae Chapter*

# Medical Information & Treatment Authorization for Youth Programs

Name of Minor _____

Address _____

City _____ State _____ Zip Code _____

Gender ☐ M ☐ F Date of Birth _____ Height _____ Weight _____

Parent/Guardian #1 _____

Home Phone _____ Cell Phone _____

Email Address _____

Parent/Guardian #2 _____

Home Phone _____ Cell Phone _____

Email Address _____

If for any reason, you cannot be reached, please indicate who you authorize us to contact, in case of a medical emergency that can make medical decisions for your child.

Name _____ Relationship to Minor _____

Home Phone _____ Cell Phone _____

Email Address _____

Name _____ Relationship to Minor _____

Home Phone _____ Cell Phone _____

Email Address _____

**PHYSICAN & INSURANCE INFORMATION**

Name of Child's Physician _____ Phone _____

Health Insurance Company _____ Phone _____

Policy Number _____ Group Number _____

Insurance Company Address _____

City/State/Zip Code _____

Name of Policy Holder _____

Name of Policy Holder's Employer _____

_____ Parent Initials

**HEALTH INFORMATION**

Below please check any current health condition that may require attention while participating in the Delta Academy/Delta GEMS program.

☐ Allergies/Sensitivities (be specific)

Foods _____

_____

*(Please include all food restrictions, including those designated for religious or personal reasons.)*

Medicines _____

Bee sting or insect bite _____

Other _____

☐ Asthma

☐ Inhaler required during program sessions and field trips

☐ Vision Problems

☐ Glasses ☐ Contacts

☐ Hearing Problems

☐ Hearing Aid(s)/Cochlear Implants

☐ ADD/ADHD

☐ Other _____

_____

**HEALTH HISTORY**

Childhood Illnesses (check all that apply):

☐ Measles ☐ Mumps ☐ Diabetes ☐ Epilepsy ☐ Chickenpox

☐ Rheumatic Fever ☐ Whooping Cough ☐ Poliomyelitis ☐ Hay Fever

☐ Ten-Day Measles (Rubella) ☐ Three-Day Measles (Rubella)

Please describe any significant health history, conditions, communicable illness, or restrictions that may affect your child's participation in the Delta Academy/Delta GEMS youth programs.

_____

_____

_____

Please specify any other serious or severe illnesses or accidents that a medical professional would need to know if treating your child.

_____

_____

_____

Does child take any prescribed medications? ☐ Yes ☐ No

List all medications, dosages and frequency your child receives on a continual basis. *(For any prescription medications or treatment required during the course of the Delta Academy/Delta GEMS youth programs, a Medication Authorization Form must be completed and submitted with this form.)*

_____

_____

_____

**NON-PRESCRIPTION MEDICATION PERMIT**

Please check those medications you give permission for your child to receive (generic equivalents may be used). I/We understand that medication will be administered with direction by an authorized program volunteer and in accordance with medication label instructions.

The following non-prescription medication may be given to my child:

☐ For headache, fever, muscle ache, pain, cramps: Acetaminophen (i.e., Tylenol, including junior strength), Ibuprofen (i.e., Advil, Motrin), Naproxen (Aleve), Midol, and Excedrin

☐ For bites/allergic rashes: Anti-itching lotion (i.e., Calamine or Hydrocortisone cream 1%), Benadryl liquid or capsules

☐ For nasal congestion/sinus pressure: Decongestant

☐ For sore throat: Throat lozenges (i.e., Cepacol lozenges)

☐ For coughs: Cough drops/lozenges or cough suppressant (i.e., Ricola)

☐ For upset stomach: Antacid liquid or chewable tablets (i.e., Mylanta)

☐ For sun protection: Sunscreen lotion SPF 30+

☐ I DO NOT WANT ANY MEDICATIONS GIVEN TO MY CHILD.

In the event that program volunteers are unable to reach any of the individuals listed on this form promptly by phone, I/We authorize Delta Sigma Theta Sorority, Inc. to seek and secure any emergency medical or surgical care for my child. I/We will be responsible for any and all expenses incurred and authorize the medical facility at which treatment is rendered to release all necessary information to my/our insurance company.

| Print Name of Parent/Guardian | Signature | Date |
|---|---|---|
| | | |

| Print Name of Parent/Guardian | Signature | Date |
|---|---|---|
| | | |

_____ Parent Initials