

HEALTH INFORMATION SHEET & MEDICAL RELEASE

For the Trip to \_\_\_\_\_

Dates: \_\_\_\_\_

A. GENERAL INFORMATION

Dancer Name \_\_\_\_\_  
(last) (first) (middle)

Birthdate \_\_\_\_\_ Present age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Parents: Father \_\_\_\_\_ Wk Phone \_\_\_\_\_  
Hm Phone \_\_\_\_\_

Mother \_\_\_\_\_ Wk Phone \_\_\_\_\_  
Hm Phone \_\_\_\_\_

Is this the first time the dancer will be away from home for an extended period? \_\_\_\_\_

If dancer gets homesick, what should be done? \_\_\_\_\_

B. HEALTH CONDITION

1. Are there any special health conditions of which we should be aware? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. How much sleep does your child require each night? \_\_\_\_\_

3. Is the dancer on medication regularly? Yes \_\_\_ No \_\_\_  
Medication \_\_\_\_\_ Medical Condition \_\_\_\_\_

Special handling required (syringes, refrigeration)? \_\_\_\_\_

Medication \_\_\_\_\_ Medical Condition \_\_\_\_\_

Special handling required? \_\_\_\_\_

Did you send medication with your child? Yes \_\_\_ No \_\_\_

Medication \_\_\_\_\_ Dosage/frequency \_\_\_\_\_

When and under what condition should the medication be given? \_\_\_\_\_  
\_\_\_\_\_

Medication \_\_\_\_\_ Dosage/frequency \_\_\_\_\_

Condition to give medication \_\_\_\_\_

“I authorize \_\_\_\_\_ to give my child, \_\_\_\_\_  
the above regular medications and have explained how and when they should be given.”

Parent/guardian \_\_\_\_\_ date \_\_\_\_\_

4. Is the dancer currently under medical treatment? Yes\_\_\_\_No\_\_\_\_

For what condition(s)? \_\_\_\_\_

5. Has the dancer had an injury in the last 12 months? Yes\_\_\_\_No\_\_\_\_

What was the injury? \_\_\_\_\_

6. Please indicate the following diseases or conditions this dancer has had or may have.  
Please provide instructions for handling the situation should it occur.

| Yes | No  | Usual Treatment                     |
|-----|-----|-------------------------------------|
| ___ | ___ | Asthma _____                        |
| ___ | ___ | Allergies _____                     |
|     |     | Food (what food)_____               |
|     |     | Insect bites _____                  |
|     |     | Soap_____                           |
|     |     | Medication _____                    |
|     |     | Other _____                         |
| ___ | ___ | Hay Fever _____                     |
| ___ | ___ | Frequent Ear Aches _____            |
| ___ | ___ | Frequent Sore Throats _____         |
| ___ | ___ | Frequent nose bleeds _____          |
| ___ | ___ | Frequent stomach aches _____        |
| ___ | ___ | Frequent pains in legs/joints _____ |
| ___ | ___ | Vision problems _____               |
| ___ | ___ | Bladder/Urinary problems _____      |
| ___ | ___ | Epilepsy _____                      |
| ___ | ___ | Diabetes _____                      |
| ___ | ___ | Other _____                         |

C. IMMUNIZATIONS AND TESTS (give age or date). Write "No" if not received.

DPT (Diphtheria, Whooping Cough, Tetanus) #1\_\_\_\_ #2\_\_\_\_ #3\_\_\_\_ #4\_\_\_\_ #5\_\_\_\_

or DT (Diphtheria, Tetanus) #1\_\_\_\_ #2\_\_\_\_ #3\_\_\_\_ #4\_\_\_\_ #5\_\_\_\_

Polio #1\_\_\_\_ #2\_\_\_\_ #3\_\_\_\_ #4\_\_\_\_ #5\_\_\_\_

MMR (Measles, Mumps Rubella) #1\_\_\_\_ #2\_\_\_\_

Hep A #1\_\_\_\_ #2\_\_\_\_

Hep B #1\_\_\_\_ #2\_\_\_\_ #3\_\_\_\_

Tuberculin Skin Test? Yes\_\_\_\_ No\_\_\_\_ Date\_\_\_\_ Result \_\_\_\_\_

At what ages did the dancer have any of the following diseases?

Chicken pox \_\_\_\_\_ Measles \_\_\_\_\_

D. HEALTH CARE RELEASE

1. Other than parents, whom should we contact in case of emergency?

\_\_\_\_\_ Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Phone \_\_\_\_\_

2. Does the company have your permission to dispense Ibuprofen?

"I give my permission to dispense Ibuprofen to my child, \_\_\_\_\_.

Usual dosage \_\_\_\_\_ child/adult \_\_\_\_\_."

Parent/Guardian \_\_\_\_\_ date \_\_\_\_\_

3. Does the company have your permission to dispense a nasal decongestant or antihistamine?

"I give my permission to dispense decongestant to my child, \_\_\_\_\_

Usual dosage: 1 tsp/4 hours or \_\_\_\_\_."

Parent/Guardian \_\_\_\_\_ date \_\_\_\_\_

4. Does the company have your permission to dispense allergy medication for temporary relief of allergies?

"I give my permission to dispense allergy medication to my child, \_\_\_\_\_

Usual dosage: 1-2 tsp every 4-6 hours or \_\_\_\_\_."

Parent/Guardian \_\_\_\_\_ date \_\_\_\_\_

5. Does the company have your permission to seek medical care for your child in the case of emergency, illness, accident, or hospitalization?

“I give my permission to seek medical care for my child \_\_\_\_\_  
in the case of emergency, illness or accident, including hospitalization.”

Parent/Guardian \_\_\_\_\_ date \_\_\_\_\_

Should an Insurance Company be notified at the time of emergency care? Yes\_\_\_\_ No\_\_\_\_

Name of Company \_\_\_\_\_ Phone \_\_\_\_\_

After Hours Phone \_\_\_\_\_

Contract Holder \_\_\_\_\_

Group and/or Individual member number \_\_\_\_\_