Valley of the Moon Scottish Fiddling School

MINOR HEALTH HISTORY AND MEDICAL RECORD
► To be completed by parent ◄

Participant Name_____ Age _____
Address _____ Sex M F
City/St_____ Zip _____ Birthdate _____
Home phone _____ email: _____
Parent/Guardian _____ Business phone _____
Parent/Guardian _____ Business phone _____
Emergency contact _____Phone _____
Health insurance: _____ Plan # / ID#_____
Doctor _____ Phone _____
Dentist _____ Phone _____

HEALTH HISTORY

1. Recent surgery or serious injury (explain) _____
2. Recent exposure to any contagious diseases (explain) _____
3. Currently taking medication (explain) _____
   (Send dosage, instructions & label correctly)
4. Any behavioral conditions (explain) _____
5. Are child's immunizations up to date? ___ yes ___ no
6. Date of last tetanus shot: _____

Please check any of the conditions that apply to your child:

__ASTHMA __EPILEPSY __DIABETES __ BLEEDING __ POISON OAK
__ INSECT BITES __ CONTACT LENSES __ HEARING AID __ ALLERGIES

Explain _____

OTHER _____

_____

The above general information and health history is correct to the best of my knowledge.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I, the undersigned, hereby grant permission to the medical personnel selected by the VOM staff, with the approval of my child's guardian _____, to order the necessary treatment for my child in the event of an emergency and I cannot be reached. I also grant permission to the physician selected by the VOM staff to secure proper treatment for injection and/or anesthesia, and/or surgery for my child as named above. In addition, I authorize the medical facility that has provided the treatment to the above named child, to surrender custody of said minor to the Guardian or VOM staff upon completion of treatment. This form may be photocopied for off-site use.

PARENT/GUARDIAN _____DATE _____

Any questions, email vomreg@gmail.com