

# MEDICAL HISTORY & AUTHORIZATION FORM



Carlisle  
Christian  
Academy

## Student Information

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
MM/DD/YY  
Gender:  Male  Female

## Emergency Contact

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

## Insurance Information

Insurance Provider: \_\_\_\_\_  
Policy/Group  
Number: \_\_\_\_\_

## Please check all that your child has now or had in the past:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Bleeding/clotting | <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Convulsions/<br>seisures                      | <input type="checkbox"/> Insect sting<br>allergies           |
| <input type="checkbox"/> Ivy Poinsonings   | <input type="checkbox"/> German Measles | <input type="checkbox"/> Frequent colds,<br>sore throats, ear<br>aches | <input type="checkbox"/> Drug allergies (list<br>all below*) |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Measles        | <input type="checkbox"/> Hay fever, asthma<br>or wheezing              | <input type="checkbox"/> Other: _____                        |
| <input type="checkbox"/> Heart Trouble     | <input type="checkbox"/> Mumps          |  |  |

## Please indicate if your child has or has had in the past (explain if yes):

Current Infectious Diseases: \_\_\_\_\_  
Operations: (List dates) \_\_\_\_\_  
Serious Injuries: (List dates) \_\_\_\_\_  
Chronic or reoccurring illness: \_\_\_\_\_

## Medical Contact Information

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Allergist: \_\_\_\_\_ Phone: \_\_\_\_\_

## Allergy Information

Does your child have any known allergies?  Yes  No

If yes, list allergies: \_\_\_\_\_  
\_\_\_\_\_

## Immunization Record

I hereby authorize that my child is up-to-date on all immunizations required including:

\*Polio \*Mumps \*Diphtheria \*Pertussis (Whooping Cough)

\*Measles \*Rubella \*Hepatitis B \*Other: \_\_\_\_\_

Date of child's last tetanus shot: \_\_\_\_\_

Has your child had a health exam in the past 2 years? \_\_\_\_\_ Date of exam: \_\_\_\_\_

## Student Restrictions & Medications

Special Diet: \_\_\_\_\_

### Current Medications:

Prescription Medication(s): \_\_\_\_\_

Non-Prescription Medication(s): \_\_\_\_\_

I hereby give permission for Carlisle Christian Academy Camp Staff to administer over-the-counter medications if requested. Medications not listed below must be provided by the parent/guardian. All medications must be signed in on a daily medication log. Dosages will be administered according to directions on the bottle unless a physician directs otherwise. I release Carlisle Christian Academy Camp and Carlisle Christian Academy and its staff from liability should a reaction result from non-prescription medication.

**Please indicate over-the-counter medication that can be administered to your child:  
(Check all that apply)**

Tums

Tylenol  
(Acetaminophen)

Benadryl

Cough Drops

Advil (Ibuprofen)

Pepto-Bismol

Signature of Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

### Physicians Instructions:

Prescription Medication: \_\_\_\_\_ to be administered to \_\_\_\_\_  
by Carlisle Christian Academy Camp Staff during the child's participation in their summer  
camping program. All medication must be signed in on a daily medication log.


Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Activities to be discouraged: \_\_\_\_\_

**By signing below, I confirm that the information provided is accurate to the best of my  
knowledge.**

Signature of Parent/Guardian \_\_\_\_\_

Date: \_\_\_\_\_

 (717)249-3692

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 [carlislechristian.org](http://carlislechristian.org)