The Laurel Foundation
Empowering At-Risk Children, Youth and Families

2021 Medical History

Personal Information: Please Print Clearly ***TO BE COMPLETED BY VOLUNTEER OR STAFF MEMBER***	
Name (Last, First, Middle):	Date of Birth:
Address (Street, City, State, Zip):	
Phone #:	Cell #:

Emergency Contacts:

Name	Relation	Phone
1.		
2.		

Do you carry medical/hospital insurance? Yes _____ No_____ **If yes, please attach a copy of the card**

Indicate Carrier: Policy or Group #:

Physicians Name:	Phone:

Health and Medical History: To be completed prior to attending camp

Have you ever required any psychiatric counseling and hospitalization? Yes_____No_____If yes, please explain:

Any operations or serious injuries? Yes_____No_____If yes, please explain:

Do you have any special dietary needs?

Is your menstrual history normal? Yes_____No _____ N/A _____

Heath History
(Check only those that apply)
- ☐ Frequent Ear Infections
- ☐ Heart Defect/Disease
- ☐ Hepatitis
- ☐ Polio
- ☐ Seizures
- ☐ Diabetes
- ☐ Sickle Cell Anemia or Traits
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Bleeding/ Clotting Disorder
- ☐ Mononucleosis
- ☐ Hypertension
- ☐ Ivy Poisoning, etc.

Diseases
(Check give approximate date)
- ☐ Chicken Pox _____
- ☐ Measles_____
- ☐ Rubella _____
(German Measles)
- ☐ Mumps_____
- ☐ Earaches

Immunization History:
(Check give year of last immunization)
- ☐ Tetanus OR DPT _____
(Diphtheria, Pertussis, Tetanus)
- ☐ Mumps
- ☐ Measles
- ☐ Rubella _____
(German Measles)
- ☐ Other

Any History of:
- ☐ Sleepwalking
- ☐ Swimmer's Ear
- ☐ Fainting
- ☐ Nosebleeds

Allergies:	**Comments on other health problems:**

Medication: In accordance with Federal Drug Laws, all prescriptions sent to camp **MUST** come in Original Pharmacy Containers with dosages typed by your pharmacist. This is also true of medications "to be taken as needed". Over the counter medications must be labeled by the individual with his/her name and dosages. ***Please list all current Medications, Dosage, and What the Medication is For***:

Authorization for Consent to Treatment

I, (the undersigned)_____, do hereby authorize The Laurel Foundation as an agent for the undersigned to consent to any x-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care to be rendered under the general or special supervision and upon the advice of a physician and surgeon licensed under the previsions of the Dental Practice Act and the Medical Practice Act or of the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said hospital.

It is understood that this authorization is given in advance of any specific diagnosis or treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent to give specific his/her best judgment may deem advisable. It is further understood that the undersigned will assume the full financial responsibility for all expenses accrued for any of the foregoing services.

This authorization is given pursuant to the provisions of Section 25.8 of the civil code of California.

This authorization shall remain effective until 2018; unless sooner revoked in writing delivered to said agent. I, also hereby certify that the health history is correct so far as I know. I, also hereby authorize the licensed medical and nursing personnel of The Laurel Foundation to administer routine health and medical care, and over the counter and prescription medication including but not limited to the following conditions: cold, headaches, stomach aches, and asthma.

Signature:	Date: