Medical Information and Authorization

MEMBER NAME: _____CLUB: **Southern Tier** Adult Junior
ADDRESS: _____ SSN: _____
CITY/STATE: _____ AGE: _____ DOB: _____
PHONE: Home (____) _____ Work (____) _____

EMERGENCY CONTACTS:

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ SSN: _____
CITY/STATE: _____ AGE: _____ DOB: _____
PHONE: Home (____) _____ Work (____) _____

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ SSN: _____
CITY/STATE: _____ AGE: _____ DOB: _____
PHONE: Home (____) _____ Work (____) _____

MEMBER PHYSICIANS:

PHYSICIAN'S NAME: _____ PHONE: _____
DENTIST'S NAME: _____ PHONE: _____

MEDICAL INSURANCE:
MEDICAL INSURANCE AGENCY: _____POLICY#_____

HEALTH HISTORY
PLEASE CHECK ALL AND ANY PHYSICAL CONDITIONS THAT ANY EMERGENCY PHYSICAIN SHOULD KNOW:

___ASTHMA	___EMOTIONAL UPSETS	___RHEUMATIC FEVER
___BLEEDING/CLOTTING DISORDER		___FREQUENT COLDS
___SISUSITUS	___BRONCHITIS	___FREQUENT SORES
___STOMACH UPSETS	___CONVULSIONS	___FREQUENT EARACHES
___SLEEP WALKING	___HEART CONDITION	___DIABETES
___DRAINING EAR	___LACK OF COORDINATION	___HYPERACTIVITY
___LUNG CONDITIONS	___OTHER	

_____

ALLERGIES:
TO **MEDICATION**: ___PENICILLIN ___ASPIRIN ___OTHER_____
_____
WILL THE MEMBER REQUIRE IMMEDIATIATE MEDICAL ATTENTION YES NO
PLEASE SPECIFY:
_____
_____

TO **BEES**: DOSE THE MEMBER CARRY A BEE STING KIT YES NO
WILL THE MEMBER REQUIRE IMMEDIATE MEDICAL ATTENTION YES NO
PLEASE SPECIFTY:
_____

TO **FOOD**: ___MILK ___EGGS ___OTHER
_____
WILL THE MEMBER REQUIRE IMMEDIATE MEDICAL ATTENTION YES NO
PLEASE SPECIFTY:
_____

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OTHER ALLERGIES: DESCRIBE:

_____

_____

WILL THE MEMBER REQUIRE IMMEDIATE MEDICAL ATTENTION YES NO

IMMUNIZATIONS:

DATE OF LAST DOSW OF TETANUS: _____

MEDICATIONS:

IS THE MEMBER ON ANY PRESCRIPTION MEDICATION? YES NO
IS THE MEMBER UNDER A PHYSICIANS CARE? YES NO
WILL THE MEMBER BE SENT WITH MEDICATION? YES NO
PLEASE INCLUDE PERTINENT INFORMATION AND INSTRUCTIONS:

_____

IF THE MEMBER REQUEST, STAFF MAY GIVE: ___ASPIRIN ___TYLENOL

OTHER INFORMATION

DESCRIBE ANY OTHER INFORMATION THAT AN EMERGENCY PHYSICIAN SHOULD KNOW:

_____

_____

ACTIVITY LIMITATIONS (For youth Members)

DESCRIBE ANY ACTIVITIES THAT THE MEMBER SHOULD NOT PARTICAPE IN:

_____

MY CHILD HAS PERMISSION TO SWIM IF INCLUDED IN THE PROGRAM SCHEDULE: Yes/No

HOW WOULD YOU RATE YOUTH'S SWIMMING ACTIVITY?

___NON-SWIMMER ___POOR ___FAIR ___AVG ___ABOVE AVG.

*****EACH YOUTH MUST HAVE A COAST GUARD APPROVED LIFE JACKET THAT FITS PROPERLY*****

AUTHORIZATION:

I hereby understand that participants will be supervised and that if a health problem or injury arises, I will be notified as soon as possible. If I cannot be reached by telephone, such medical treatment and /or hospital care can be administered by competent medical personal including medication, injections, anesthesia, surgery, or other treatment for the member as named above and necessary information may be released for insurance purpose. I verify that all health problems/concerns are noted above. By this registration, I grant permission for the member listed above to take part in the SOUTHERN TIER JR. BASSMASTERS CLUB, as indicated and I hereby release them and the Chapter, The New York State B.A.S.S. Federation and its staff, volunteers, and sponsors from all liabilities associated with this activity.

_____

_____ _____

PRINTED NAME OF MEMBER PRINTED NAMED OF PARENT/GAUARDIAN

_____ ___/___/____ _____ ___/___/____

SIGNATURE DATE SIGNATURE DATE