

Educational Programs

Medical Information Form



The Medical Information Form is kept confidential and used by our program staff (or emergency medical personnel).
Every participant must have a completed Medical Information Form submitted four (4) weeks prior to the event.
Completed forms should be emailed to overnights@spacecenter.org as an attachment or clear photograph.

Participant Information PLEASE PRINT NEATLY

<i>Date of Overnight Experience</i>	<i>Pack Number/Troop Number/Group Name</i>					Male	Female
<i>Participant First Name</i>	<i>Middle</i>	<i>Last Name</i>	<i>Date of Birth</i>	<i>Age</i>	<i>Gender</i>		
<i>Contact Parent/Guardian #1</i>	<i>Relationship</i>			<i>Daytime Phone</i>			
<i>Contact Parent/Guardian #2</i>	<i>Relationship</i>			<i>Daytime Phone</i>			

Allergies

No known allergies Participant is allergic to: Food Other
Please list all allergies below:

Participant does have an Epi-Pen? YES NO

*If participant is bringing an Epi-Pen, SCH is required to have a current, signed Physician's Authorization Form five (5) days prior to the first day of program. SCH cannot administer medication to participants without physician authorization. Participants are required to bring Epi-Pens each day.

Restrictions

If your child has a disability, impairment or condition that requires medication or other accommodations, please inform SCH of your child's needs below, prior to program, to ensure that SCH is prepared to address your child's needs. Once a parent/guardian submits a modification request, SCH will consider that request on a case-by-case basis and will attempt to accommodate your child within a reasonable amount of time.

Does your child have a disability, impairment or condition that requires medication, or any other accommodations?
YES NO If yes, please describe below:

Parent/Guardian Authorization

My child has permission to engage in all prescribed program activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including activity limitations, or conditions which should be known to the Education staff and medical personnel. I give consent in advance for medical treatment at the closest facility in case of illness or injury.

Signature of Custodial Parent/Guardian

Date

Relationship to Participant