

9th and 10th CWW Medical Information Sheet

Student Name – Please Print: _____
ID Number: _____ Passport Number: _____
Nationality: _____
Parent/ Legal Guardian: _____
Telephone: _____ (Cell#): _____
Guardian's Place of Employment: _____
Work Phone: _____ Extension: _____
If Unable to Contact the Above, Call (Name): _____
Telephone: _____ (Cell#): _____
Family Physician: _____ Telephone: _____
Insurance Co. and Policy Holder: _____
Policy/ Account Number: _____

Medical Information at a Glance

1. Can you swim? Yes _____ No _____
2. Do you have asthma? Yes _____ No _____
3. CPR or First Aid certification (Red Cross or equivalent)? (Not Required):
CPR _____ Expiration Date: _____
First Aid _____ Expiration Date: _____
4. Are you allergic to bee stings or other antigens that cause anaphylaxis (nuts, shellfish, insect bites, etc.)? Yes _____ No _____
If so, do you carry an EpiPin? Yes _____ No _____
5. Are you currently on any medication? Yes _____ No _____
If so, please list: _____
6. Are you allergic to any medication? Yes _____ No _____
If so, please list: _____
7. Blood Type: _____
8. Major surgery in the last year? Yes _____ No _____
If so, please list: _____
9. Please list any acute or chronic medical conditions: _____

10. Do you have any special dietary needs? Please list: _____
11. Have you been vaccinated for yellow fever? Yes _____ No _____
Expiration Date: _____

Signatures:

I hereby give permission for the staff of ACS to seek appropriate medical attention for the student, and for medical attention to be given in the event of accident, injury, or illness. I will be responsible for any and all costs of medical attention and treatment.

Parent/ Legal Guardian: _____ Date: _____
(Please Sign)

I certify that the information that I have provided above is accurate to the best of my knowledge.

Student: _____ Date: _____
(Please Sign)