



**MEDICAL INFORMATION FORM**  
**TO BE FILLED OUT BY THE PARENT/GUARDIAN**

(Please complete form using black ballpoint pen)

This form is to be filled out, signed by parent/guardian & checked with physician at time of examination.

Participants

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_  
Last First Initial

Parent or Guardian: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Business Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

If parent or guardian is not available in an emergency, please notify:

1. \_\_\_\_\_  
Name & Complete Address

\_\_\_\_\_  
Relationship to Participant Area Code & Telephone Number (\_\_\_\_) \_\_\_\_\_

2. \_\_\_\_\_  
Name & Complete Address

\_\_\_\_\_  
Relationship to Participant Area Code & Telephone Number (\_\_\_\_) \_\_\_\_\_

**HEALTH HISTORY:** (please check-off, giving approximate dates)

CONDITIONS	DISEASES	ALLERGIES
Anorexia _____	Chicken Pox _____	Hay Fever _____
Bulimia _____	Measles _____	Ivy Poisoning _____
Dyslexia _____	German Measles _____	Insect Stings _____
Psychological Counseling _____	Mumps _____	Penicillin _____
Short Term _____	Asthma _____	Other Drugs _____
Long Term _____	ADD _____	ADHD _____ (please indicate)

Operations or Serious Injuries (list & give details): \_\_\_\_\_

Meds Presently taking: \_\_\_\_\_

Chronic or Recurring Illness: \_\_\_\_\_

Other Diseases or Details of Above: \_\_\_\_\_

**PARENT'S OR GUARDIAN'S AUTHORIZATION:** This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the examining physician. In the event of an emergency, after an effort has been made to contact the parents, guardian or those listed in the North American Emergency Contact form (and above), I hereby give permission to the physician selected by KE supervisory personnel to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child.

**PARENT'S OR GUARDIAN'S SIGNATURE:**

\_\_\_\_\_  
IMPORTANT: Please notify ETG if this participant is exposed to any communicable disease during the three weeks prior to program departure. **PARENTS/GUARDIANS: please be certain to submit this form to your child's physician along with the Physician's Medical Form enclosed in this package.**

**PARENTS-GUARDIANS: Did you sign above?**