

2009-2010 NCSY MEDICAL HISTORY & TREATMENT CONSENT FORM

NCSYER PERSONAL INFORMATION

NCSYers Name:	NCSYers Home Telephone:
Date of Birth:	NCSYers Cell:
Gender:	School:
Street Address:	Grade:
City, State, Zip	Chapter:
E-Mail Address:	

PARENT OR GUARDIAN #1

PARENT OR GUARDIAN #2

Name:	Name:
Home Phone:	Home Phone:
E-Mail:	E-Mail:
Cell:	Cell:
Employer:	Employer:
Work Telephone:	Work Telephone:
<i>if different from above</i>	<i>if different from above</i>
Street Address:	Street Address:
City, State, Zip:	City, State, Zip:

EMERGENCY CONTACT IF PARENTS/GUARDIANS CAN NOT BE REACHED

Name:	Street Address:
Telephone:	City, State, Zip:
Cellular:	Relationship to NCSYer:

PHYSICIAN INFORMATION

Name:	Telephone:
Street Address:	City, State, Zip:

MEDICAL INSURANCE PLAN

Carrier:	Insured Name:
Identification Number:	Group Number:
Claim Address:	Telephone:



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MEDICATIONS. Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Please send the medication in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration. *Withholding this information may put your child in serious danger and delay medical treatment.* NCSY may provide over-the-counter medication (Tylenol, Advil, Kaopectate, Benadryl, etc.) as deemed necessary. I understand that this does not require NCSY to provide medical treatment.

_____ This NCSYer takes NO medications on a routine basis.

Medicine	Dosage	Time of Day	Reason for Taking

ALLERGIES. Attach additional pages if necessary

Food / Medicine / Item Allergic To:	Reaction & Management of the Reaction:

ANY ADDITIONAL INFORMATION ABOUT THE NCSYER'S BEHAVIOR AND PHYSICAL, EMOTIONAL, OR MENTAL HEALTH ABOUT WHICH NCSY SHOULD BE AWARE?

I, _____ (parent/guardian), do hereby give permission to the administration of NCSY to secure emergency medical treatment for the child indicated above. This includes, but is not limited to: transporting and admitting my child to an appropriate hospital or medical facility, administering medications, emergency surgery if indicated, and further providing care as deemed necessary. I further understand that NCSY will attempt to contact me as soon as possible and that emergency care will be continued at the discretion of the administration or their designee until such time as I am available to make further decisions.

I, _____ (parent/guardian) realize that this information is most effective if kept current. We will make every attempt to inform Central East NCSY and our local chapter advisors of any changes to this form as soon as possible. I authorize NCSY to share the above information with NCSY personnel as necessary.

Name printed: _____

Signature: _____ Date: _____

