The Connection
for women & families

MEDICAL FORM

Date: _____

Participant's name: _____ D.O.B: _____ Age: _____ Gender: _____

_____
Home phone *Work phone*

_____
E-mail

Emergency contact: _____
Name *Relationship*

Health Concerns

Medical conditions/information: _____

_____

Are there activities that need to be restricted? _____

_____

Known allergies: _____

Physician's name: _____ Phone: _____

NOTE: All children must have protection against diphtheria, tetanus, poliomyelitis, measles, pertussis, mumps and rubella.

❑Date of last tetanus shot: _____ OR

❑I am attaching a written statement from my child's physician stating that immunization is in progress.

Date of most recent physical examination: _____

MEDICAL RELEASE: *This health information is correct so far as I know, and the person herein described has permission to engage in all activities at The Connection, except as noted by me. In the event of an emergency, I give permission to The Connection to obtain necessary emergency medical treatment as needed for my child.*

Parent/Guardian/Adult Participant: _____ **Date:** _____