

STUDENT DELEGATE MEDICAL FORM

Revised May 2018

North Carolina Association of Student Councils, Inc.

This is an editable PDF. Click on the line to enter the requested information. You can use the Tab key to move from field to field. Most fields **REQUIRE** a response. **After completion, PRINT** the form and obtain parent/guardian signature at bottom - **REQUIRED**.

Completed on _____ by _____ School _____
Spell out name...not just initials

Personal

Name _____ Date of Birth _____ Sex _____
First Middle Last m-d-yy M or F

Address _____
Number & Street City State Zip

Emergency Names & Phone Numbers

Enter Phone #s in this format: 000-111-2222 Home Landline _____ Student Cell _____
Phone Numbers Phone Numbers

Parent / Guardian Name #1 _____ #2 _____

If parent can not be reached, Name _____ Relationship to Student _____

Student's Physician Name _____ Clinic Name _____

Insurance

Does student have medical insurance? _____ Enter **YES** or **NO** Phone Number _____

If **NO**, who is responsible for medical payments? _____

If **YES**, Insurance Company _____ Policy Info: # _____ ID# _____ Group# _____

Insurance Company Phone _____ Address _____

Brief Medical History

Allergies or special needs _____

Current Medications and Dosing Info: _____

Enter **YES** or **NO** *Please bring an adequate supply in a labeled container (preferably the pharmacy-dispensed container).*

Asthma _____ Medication _____
Diabetes _____ Medication _____
Epilepsy _____ Medication _____

Tetanus vaccination up-to-date? _____ Enter **YES** or **NO** Date, if known _____

Should student be **restricted** from any type of activity? _____ Enter **YES** or **NO** and if YES, list and/or explain below.

Restricted Activities _____

Are there any prescription or non-prescription drugs that should **NOT** be administered? _____ Enter **YES** or **NO** and if YES, list below.

Prohibited medications _____

Please enter below **any other pertinent information** of which we should be aware in the event of an emergency. Attach additional sheet if necessary.

I, the parent or legal guardian of _____, authorize and direct the North Carolina Association of Student Councils (NCASC) to obtain medical care for my child in the event such care is reasonably necessary. I understand that, if possible, I will be contacted in the event my child requires medical attention. I grant to a licensed health care provider or accredited hospital permission to perform any reasonably necessary medical and/or surgical procedures that are essential for the treatment of my child and agree to be responsible for payment of such care. I release NCASC, its employees, and agents from any damages, liability, or loss resulting from their discretion in securing in good faith medical care for my child.

Enter Parent / Guardian Name Signing Form

Signature

Date