



# NCASC MEDICAL FORM

North Carolina Association of Student Councils, Inc.

**DO NOT HAND COMPLETE**

*This is an **editable PDF**. **DOWNLOAD TO YOUR COMPUTER**. Then open and complete. 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**, save it on your computer. **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: \_\_\_\_\_  
*Please bring an adequate supply in a labeled container (preferably the pharmacy-dispensed container).*

### COVID Information (as of the completion of this form) Vaccination Status

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 authorize the North Carolina Association of Student Councils (NCASC) to obtain medical care and arrange for necessary related transportation 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 emergency 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 the licensed provider and 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 Name of Parent / Guardian Signing Form

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date Signed