STUDENT DELEGATE MEDICAL FORM

Revised 8-11

North Carolina Association of Student Councils

(Please print or type; Please fill in this form COMPLETELY. All information is important in the event of an emergency.)

School_____

Name:_____ | _____ | _____ DOB:_____ M F
First *Middle* *Last*

Address:_____
Number & Street *City* *State* *Zip*

Home Telephone: (_____) _____ Parent's Name:_____

Parent's Daytime Phone: (_____) _____ Other Emergency Number: (_____) _____

Who is responsible for medical payments? ___Individual ___Insurance Policy #_____

Medical Insurance Company Name:_____

Address:_____
Number & Street *City* *State* *Zip*

Delegate's Physician's Name_____ Telephone: (_____) _____

— Brief Medical History —

*Please print **NONE** if any item is not applicable & use back if necessary*

Special Health Concerns:_____

Medications: _____Dosage per day: _____
NOTE: If you are taking medication regularly, please bring a supply in the pharmacy-dispensed container..

Asthma: ___Yes ___No Medication:_____
Diabetes: ___Yes ___No Medication:_____
Epilepsy: ___Yes ___No Medication:_____
Date of Last Tetanus vaccination: _____

Should delegate be restricted from any type of activity? ___Yes ___No
If yes, please explain:_____

Are there any prescription or non-prescription drugs that should **NOT** be administered? ___Yes ___No
Type of prohibited medications:_____

Any other pertinent information which should be known in the event of emergency?_____

I, the parent or legal guardian of the above-named child, authorize the North Carolina Association of Student Councils to obtain medical care for my child in the event such care is 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 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 and its agents from any damages, liability, or loss resulting from their securing in good faith medical care for my child.

Signed: _____ **Date:** _____
Parent or Guardian