



# YOUTH PROGRAM MEDICAL INFORMATION FORM

Student's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Are there any **medical problems** or **conditions** of which we need to be aware?  Yes  No

If yes, please explain:

Is the student taking any **medications**?  Yes  No

If yes, please list medications and how often they are taken:

Does the student have any **allergies**?  Yes  No

If yes, please list allergies to medicine or food, as well as environmental allergies:

May we give your child any of the following without calling you:

Aspirin	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Tylenol	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Ibuprofen	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Names and phone numbers of **parents/guardians, friends or relatives** we may contact in case of emergency.

Name	Phone Number	Type of number	Relationship
_____	_____	home work cell	_____
_____	_____	home work cell	_____
_____	_____	home work cell	_____
_____	_____	home work cell	_____

In case of emergency, I, \_\_\_\_\_, give my permission to Ocala Civic Theatre to  
Name of Parent or Guardian  
 obtain emergency medical treatment for my child \_\_\_\_\_.  
Name of Child

Signature: \_\_\_\_\_

Date: \_\_\_\_\_