

REQUIRED FOR SOUND TO SEA PARTICIPATION

Name _____
Last _____ First _____ Middle _____
School _____

Student Medical Form

Name _____ Age _____
Address _____ City _____ State _____ Zip _____
Date of Birth ____ - ____ - ____ Sex ____ Weight _____ Height ____ft ____in

Parents or Guardians _____
Home Phone (____)____ - _____ Work Phone (____)____ - _____
Home Phone (____)____ - _____ Work Phone (____)____ - _____
Cell Phone (____)____ - _____ Cell Phone (____)____ - _____
Family Physician/Doctor _____ Phone (____)____ - _____
In case of emergency, notify the following if a parent cannot be reached:
Name _____ Relationship _____ Phone (____)____ - _____
Name _____ Relationship _____ Phone (____)____ - _____

**These must
be filled in.**

Home and Health Questionnaire

- 1 Please list date of the student's last diphtheria-tetanus or tetanus booster _____. (Must be current).
- 2 Is this the student's first prolonged stay away from home? _____ First sleep away experience? _____
- 3 Has the student ever had a problem with homesickness? _____ Please explain: _____

- 4 Does the student have a bed-wetting problem? _____
- 5 Please list any current activity restrictions or other concerns (such as recent sprains, fractured bones, recent hospitalizations, learning disabilities, physical disabilities, special diet (vegetarian/religious restrictions) _____

- 6 Please list any allergies (including food, environmental, medication) and **explain degree of severity and treatment.** (For example: if your child is allergic to peanuts, do they react to eating the nut itself, products containing peanut oils, food processed on machines that also process nuts, or all three?) _____

- 7 **IF YOUR CHILD HAS AN ANAPHYLACTIC (EPI-PEN) ALLERGY** to anything, please describe in detail what things should be avoided, and what reactions we should watch for. **If it is a food allergy, please let us know if it is an allergy of ingestion, contact and/or inhalation and if there are other types of exposure that would be harmful to your child.** _____

- 8 Please list any chronic or recurring illnesses (ear/throat infections, asthma, diabetes, convulsions, etc.) and explain _____

- 9 Additional information _____
