FJM Clinics Health Form

Name________________________________ Clinic Location________________Clinic Date__________

SCHOOL/GROUP____

This form is to be completed by parent or guardian. It is not necessary to have student examined by a family physician. Please bring the completed health form to registration at the clinic site.

NAME: LAST, FIRST, MIDDLE | SEX | BIRTHDATE | AGE

ADDRESS | CITY | STATE | ZIP | TELEPHONE

IN CASE OF EMERGENCY PLEASE NOTIFY: | HOME PHONE | WORK PHONE

FAMILY PHYSICIAN | PHYSICIAN PHONE

MEDICAL HISTORY:

- ☐ **Medications**
- ☐ **Seizures**
- ☐ **Diabetes**
- ☐ **Heart disease**
- ☐ **Bleeding disorder**
- ☐ **Asthma**
- ☐ **Surgeries**
- ☐ **Chicken Pox**
- ☐ **Measles**
- ☐ **Allergies**

EXPLANATION OF ANY OF THE ABOVE:

Date of Last Tetanus Immunization:____

Physical, medical or other restrictions that would limit camp activities:______________________________

INSURANCE CARRIER:______________________________ POLICY/GROUP #____________________
(please enclose copy of insurance card if possible)

CONSENT FORM/RESPONSIBILITY CLAUSE

To my knowledge, all of above is correct and my child is of good health as of (date)______. I understand that in an event of a medical emergency, every effort will be made to contact the parent/guardian of the student. If I cannot be reached, I hereby give my permission to the physician selected by the Clinic Administrator to: Hospitalize; secure proper treatment for injections, anesthesia or surgery for my child as named above.

I also understand that FJM Clinics, its directors, agents and employees shall not be nor later become, liable or responsible in any way in conjunction with services, for any death, injury, damage, delay or irregularity which may occur while participating in this FJM Clinic event.

SIGNATURE OF PARENT OR GUARDIAN____DATE:________________

PLEASE BRING COMPLETED FORM TO CLINIC REGISTRATION