Illinois Rainbow Health Form

Name _____

Birth date_____

Parent/Guardian_____

Address_____

_____

Phone:_____
Home Work

_____
Cell Pager

EMERGENCY CONTACTS

1._____
name home phone

_____
alternate way to contact

2._____
name home phone

_____
alternate way to contact

MEDICAL HISTORY

Diabetes_____Epilepsy/seizures_____HTN_____
Cardiac_____LungDisease_____Asthma_____
Renal Disease_____Cancer_____Ulcers_____
Thyroid___Chickenpox____Measles/Mumps_____
Swimmer's ear_____Ear infections_____
Cold/Cough/Sore Throat (last 2 weeks)_____
Pertinent family history_____
_____
_____

PAST HOSPITALIZATIONS/SURGERIES
Please include month and year
_____
_____
_____
_____
_____
_____

IMMUNIZATIONS
Up to date: yes/no
Last Tetanus:

RESTRICTED ACTIVITIES

ALLERGIES (please include child's reactions)
Meds_____Food_____Contact_____Latex_____
List:_____
_____
_____

MEDICATIONS:
(Please bring all medications in original bottle we must know about everything including over the counter medications (see reverse for specific over the counter medications)

Medication dose frequency use
_____
_____
_____
_____
_____
_____
_____

HOME DIET:

Home diet:_____
Please list all special diet requirements (i.e. Vegetarian, dairy intolerance, no caffeine, etc.)
_____
_____
_____

PRIMARY PHYSICIAN:_____

_____
ADDRESS PHONE

INSURANCE:_____
Policy Number:_____

Parental Suggestions:
_____
_____
_____

PARENT/GUARDIAN AUTHORIZATION: This health history is correct so far as I know, and the person herein described has permission to engage in all activities, except as noted by me. I understand that the Illinois Rainbow Registered Nurse and Certified First-Aiders who will give care for usual & common medical issues and refer to the doctor on call as needed, should such an occasion arise.

SIGNATURE:_____

DATE:_____

MEMBER SIGNATURE:_____

PLEASE COMPLETE REVERSE SIDE OF THE FORM

Illinois Rainbow Health Form

Illinois Rainbow has my permission, should the need arise, to administer the following over the counter medications to my child, _____, (note, generic brand medications will be given):

___ Acetaminophen (Tylenol)
___ Naproxen (Aleve)
___ Diphenhydramine (Benadryl)
___ Calamine lotion
___ Mylanta
___ Tums
___ Rhuli Gel (Itch relief)
___ Cortisone 10 cream
___ Chloraseptic spray/lozenges
___ Ibuprofen (Advil, Motrin)
___ Sinus/Allergy Tabs (Sudafed)
___ Cough Syrup (Robitussin)
___ Maalox
___ Milk of Magnesia
___ After bite bug bite relief
___ Triple antibiotic ointment
___ Midol (menstrual relief)
___ After sun (sun burn relief)

Signed: _____, Parent / Legal Guardian Date: ____/____/____.

The following **OPTIONA**L Emergency Authorization is suggested by Local Hospitals

AUTHORIZATION FOR EMERGENCY MEDICAL AND/OR SURGICAL TREATMENT FOR A MINOR CHILD AND DESIGNATION OF PERSON AUTHORIZED TO GIVE SUBSTITUTE CONSENT FOR TREATMENT OF A MINOR CHILD

KNOW ALL MEN BY THESE PRESENTS that I (we), of (city) _____, In the County of _____ and State of Illinois, do hereby direct the Local Hospital to accept the consent of Illinois Rainbow Leaders, an adult, for any and all medical treatment which may be needed by my child, _____, when I (we) am (are) unavailable and efforts to contact me (us) are unsuccessful. I hereby authorize Illinois Rainbow Leaders, to make any and all necessary health care decisions on behalf of my child which my be required during my daughter's attendance at Illinois Rainbow for 2008.

_____ DATE_____
SIGNATURE OF PARENT/GUARDIAN

WITNESS **OR** NOTARY

_____ DATE_____
SIGNATURE OF WITNESS **OR** NOTARY

_____
Relationship of Witness **OR** Notary Stamp