

# MEDICAL FORM

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

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

YMCA: \_\_\_\_\_ School: \_\_\_\_\_

Advisor's Name: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Alternate name and number to call in case of an emergency:

\_\_\_\_\_

Family Doctor's name and number:

\_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_ Are you a diabetic? \_\_\_\_\_

Check if you have had:

\_\_\_\_\_ Measles      \_\_\_\_\_ Small Pox      \_\_\_\_\_ Pneumonia      \_\_\_\_\_ Chicken Pox

\_\_\_\_\_ Typhoid      \_\_\_\_\_ Asthma      \_\_\_\_\_ Diphtheria      \_\_\_\_\_ Polio

\_\_\_\_\_ Mumps      \_\_\_\_\_ Scarlet Fever      \_\_\_\_\_ Heart Trouble

\_\_\_\_\_ Allergy to penicillin      \_\_\_\_\_ Other Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Consent Statement: As parent/guardian of the person named above, I give my permission for him/her to participate in the New Mexico YMCA Youth and Government Program. In the event of sickness or injury, I authorize such medical treatment or diagnostic procedures as may be deemed advisable to be performed by a health care provider as shall be designated by the Executive Director, Member of the Board of Directors, Advisor, or other authorized member of the New Mexico YMCA Youth and Government Program.

I recommend normal physical activity for the above-named participant, unless otherwise specified.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date