



RYLA 2011

MEDICAL INFORMATION & HISTORY

To be completed by the youth applicant and parent/guardian.

This information is CONFIDENTIAL and is only for your safety and emergencies. This document will be destroyed after RYLA is completed.

Name: _____

Date of Birth: _____ Home Phone: _____

Address: _____

Family doctor: _____ Phone: _____

Address: _____

Health Insurance Policy and Group numbers: _____

MEDICAL HISTORY

1. Do you have any allergies (bees, drugs, foods, etc.)?

Explain: _____

2. Are you taking any medications?

List: _____

3. Do you have any chronic illnesses (diabetes, epilepsy, asthma, etc.)?

Explain: _____

4. Do you have any physical disabilities or conditions that might prevent you from participating in any physical activities?

Explain: _____

5. Special dietary needs?

Explain: _____

6. Are you currently under the care of a physician?

Explain: _____

7. Do you have any other medical conditions?

Explain: _____

X _____
Student Signature

X _____
Parent/Guardian Signature