RECORD OF MEDICAL HISTORY

ALL requested information must be completed and signed.

PLEASE TYPE OR USE INK AND PRINT CLEARLY

AMBASSADOR

Name: _____
First Middle Last

Date of birth: _____ Place of Birth: _____

Permanent Home Address: _____

_____ Telephone: _____
City State Zip Code

PARENT/GUARDIAN INFORMATION

	Mother/Guardian	Father/Guardian
Name	_____	_____
Address	_____	_____
Home Phone	_____	_____
Employer	_____	_____
Work Phone	_____	_____
Insurance Co.	_____	_____
Insurance I.D. Number	_____	_____

DOCTOR INFORMATION

Ambassador's Doctor _____

Telephone _____

Ambassador's Dentist _____

Telephone _____

Ambassador First Name _____ Last Name: _____

MEDICAL HISTORY

Past Surgery/Hospitalizations: _____

_____

_____

Name of Medication	Reason for Medication	Dose	Time (Breakfast/AM, Lunch, Dinner, Bed time/PM)

ALL MEDICATION MUST BE IN ORIGINAL CONTAINER. ALL MEDICATIONS FOR MINORS MUST BE GIVEN TO STAFF DIRECTOR UPON ARRIVAL AND DISPENSED DAILY BY HIM/HER.

Parent/Guardian Signature

_____

Ambassador First Name _____ Last Name _____

RECORD OF MEDICAL HISTORY: (Check the following conditions you have had or are subject to):

Asthma _____	Hay Fever _____	Headache _____
Digestive Upsets _____	Fainting Spells _____	Convulsions _____
Hearing Loss _____	Vision Loss _____	Nose Bleeds _____

Check the following conditions you have had:

Measles _____	Diphtheria _____	Mononucleosis _____	Tonsillectomy _____
Mumps _____	Epilepsy _____	Chicken Pox _____	Appendectomy _____
Pneumonia _____	Polio _____	German Measles _____	Heart Problems _____
Heart Disease _____	Diabetes _____	Seizures _____	Other _____

What vaccinations and immunizations have you had?

	Yes	No	Date (Month/Year)	Please list known allergies
Diphtheria, Tetanus				
Polio				
Measles				
Rubella (German Measles)				
TB Skin Test				

GENERAL

1. Do you require any special dietary considerations? Please detail:

_____

_____

2. Are there any limitations on the amount or type of physical exercise that you can engage in?

Yes _____ No _____

Describe:_____

_____

TREATMENT AUTHORIZATION

In the event that the Ambassador is a minor and needs medical treatment, I request that the parents/guardians listed on the form be contacted to authorize treatment. In the event parents/guardians cannot be reached, the following persons have been given consent to authorize treatment for the Ambassador:

Name/Relationship _____ Phone _____

Name/Relationship _____ Phone _____

PARENTAL CONSENT FOR TREATMENT OF A MINOR

If a situation occurs in which the above named Ambassador is a minor and requires immediate medical attention, and I [or an authorized individual(s)] am unable to give consent, this signed statement will serve as authorization for A-WOW World Summit, the Program Sponsor, or any of its agents to provide, obtain, or authorize any reasonable incidental and/or emergency medical treatment for the Ambassador, in the event of the Ambassador's illness, injury, or incapacity.

_____ _____

Signature of Parent (if under age 18) ***Date***