



*"Transforming One Girl at a Time"*

**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 \_\_\_\_\_

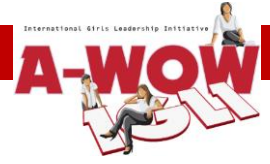
\_\_\_\_\_

Insurance Co. \_\_\_\_\_

\_\_\_\_\_

Insurance I.D. Number \_\_\_\_\_

\_\_\_\_\_



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**DOCTOR INFORMATION**

Ambassador's Doctor \_\_\_\_\_

Telephone \_\_\_\_\_

Ambassador's Dentist \_\_\_\_\_

Telephone \_\_\_\_\_

Ambassador First Name \_\_\_\_\_ Last Name: \_\_\_\_\_

**MEDICAL HISTORY**

Past Surgery/Hospitalizations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

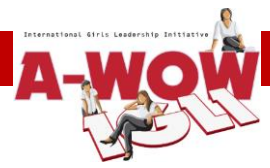
Name of Medication	Reason for Medication	Dose	Time (Breakfast/AM, Lunch, Dinner, Bed time/PM)

**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 \_\_\_\_\_



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**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**