

ALATEEN HEALTH HISTORY FORM

To be completed and signed by custodial parent/legal guardian of Alateen

INFORMATION ABOUT YOUR TEEN:

| | | |
|---------------------------------------|----------------|---------------|
| Alateen Full Legal Name: | Date of Birth: | Age: |
| Address: | | |
| Custodial Parent/Legal Guardian Name: | Phone: | |
| Physician's Name: | Phone: | |
| Emergency Contact: | Phone: | Relationship: |

| | |
|---|---------------|
| Name of persons authorized to pick up Alateen: | Phone number: |
| | |
| Names of person(s) NOT authorized to pick up Alateen: | |
| | |

PLEASE CHECK ALL THAT APPLY TO YOUR TEEN:

| | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Intestinal or Stomach Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting/Dizzy Spells | <input type="checkbox"/> Mental/Psychological Disorders |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Heart Defects/Disease | <input type="checkbox"/> Sinusitis (Sinus Infections) |
| <input type="checkbox"/> Convulsions/epilepsy/seizures | <input type="checkbox"/> Liver Trouble (Hepatitis) | <input type="checkbox"/> Sleep Disturbances/Impairment |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension/High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Other (explain below) |
| <input type="checkbox"/> My child has ongoing health concerns that are not listed above and that an ER doctor should be aware of. | | |
| <input type="checkbox"/> My child has adverse reactions to and/or sensitivity to medication in a typical first aid kit. Let us know if any of these over-the-counter medications SHOULD NOT be given in an ER: e.g., Tylenol, aspirin, aloe vera gel, calamine lotion, anti-diarrhea medication, laxative, antacid, antihistamine, hydrocortisone cream, cough, and cold medication. | | |
| <input type="checkbox"/> My child's immunizations are NOT updated in accordance with State of Georgia requirements for public schools. | | |

PLEASE EXPLAIN IN DETAIL ANY ITEMS CHECKED ABOVE. CONTINUE ON REVERSE SIDE IF NECESSARY:

HEALTH INSURANCE INFORMATION -

IN CASE OF ACCIDENT OR ILLNESS, PERSONAL INSURANCE IS PRIMARY

| | | | |
|--------------------|--|--------------------------------|--|
| Policy Holder Name | | Insurance Company | |
| Policy Number | | Insurance Company Address | |
| Group Number | | Insurance Company Phone Number | |

MEDICAL CONDITIONS AND/OR CONCERNS - Please include any precautions or restrictions on activities, as well as concerns relating to emotional and mental wellbeing (including self-harm, depression, effects of medication on their behavior, eating disorders, etc.) We want to provide the most supportive environment possible and a large part of that is knowing what is going on with Event participants:

| <i>NAME OF CONDITION</i> | <i>EFFECTS</i> |
|--------------------------|----------------|
| | |
| | |
| | |

Has the participant had any adverse reactions to general anesthetics? (circle one) YES NO

If YES, please explain:

Additional Information or Comments:

I know of no reason(s), other than the information indicated on this form, why the Alateen should not participate in activities except as noted.

Signature of Custodial Parent/Legal Guardian or Emancipated Teen:

Date _____

*Emancipated teens age 17 or under completing this form for themselves must provide a **copy** of the emancipated paperwork from Juvenile Court to the Event Registration Chair for secure retention by AFGG.

This form is necessary in case your child, or an emancipated teen requires emergency medical treatment.

This fully completed, signed form (and emancipated paperwork if appropriate) must accompany other required registration forms, be kept in a covered binder or folder by the authorized person or transporting AMIAS, and then submitted to the Registration Chair at that event. The Registration Chair (Alternate Delegate at Assembly and AWSC) will electronically scan this form at registration and deliver it to the Designated Medical Administrator (DMA) if one is present at that event. Upon event completion, the DMA will return the original form to the Registration Chair. This original form will be returned to the authorized person or transporting AMIAS, who will return it to the parent/guardian. The Registration Chair will send the scanned copy to the AAPP for secure retention after the event. This form must be completed and signed in the presence of an AMIAS or other authorized person associated with AFGG and may not be altered after being signed by the parent or guardian.