



Eastern Michigan University
The B. Side: The Business Side of Youth
Medical Information Form

In accordance with Federal Privacy Acts, any information provided shall be kept confidential.

Medical Information

Please indicate medication(s) which is/are taken on a regular basis in the space below. Please attach separate sheet if additional information is needed.

Note: If a Youth Participant needs to take any medication during the program, a physician's note is required.

Name of Medication	Dosage	Prescribing
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Is there a medical history involving any of the following:

Allergies	Yes _____	No _____	Heart Disease	Yes _____	No _____
Convulsions	_____	_____	Phobias or Fears	_____	_____
Past Injuries/Illnesses	_____	_____	Diabetes	_____	_____
Disabilities	_____	_____	Past Operations	_____	_____
Epilepsy/Seizure	_____	_____	Other (Please specify)	_____	_____

If you answered 'yes' to any of the conditions, please explain in detail. Use a separate sheet if needed:

Please advise of any special instruction, side effects or emergency procedures:

Youth Participant Signature

Date

Parent/Guardian Signature *(If under 18 years of age)*

Date



**Eastern Michigan University
The B. Side: The Business Side of Youth
Insurance Information Form**

In accordance with Federal Privacy Acts, any information provided shall be kept confidential.

Insurance Information

Private insurance information must be provided, if applicable. If a Youth Participant does not have private health insurance, please be advised that, should he/she require medical attention, **the parent/guardian (if applicable) is responsible for paying any costs not covered by insurance.**

Youth Participant's Name _____

Youth Participant's Address _____
Street City State Zip

Youth Participant's Phone Number _____ Date of Birth _____

Insurance Company Name _____ Effective Date _____

Address of Insurance Company _____
Street City State Zip

Phone Number of Insurance Company _____ Group # _____

Policy Holder's Name _____ Policy # _____

Policy Holder's Address _____
Street City State Zip

Relationship to Youth Participant _____

Contact # _____ Employer _____

Name of Primary Care Physician _____

Address of Primary Care Physician _____
Street City State Zip

Phone Number of Primary Care Physician _____

I hereby authorize the release of any medical information that might be needed in connection with payment for medical services.

Youth Participant Signature

Date

Parent/Guardian Signature *(If under 18 years of age)*

Date