

**Team 1389 Health Information Form
2026/2027**

Team Member's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____

Grade: _____

In case of emergency, notify the person below:

Name: _____

Relationship: _____

Phone 1 _____ Home Work Cell

Phone 2 _____ Home Work Cell

Alternate contact name: _____

Alternate's phone 1: _____ Home Work Cell

Alternate's phone 2: _____ Home Work Cell

Health History:

List any allergies that your child (member) has: _____

Explain any specific accommodations required: _____

Explain any activities that are discouraged or limited by your child's physician: _____

Explain any health conditions we need to be aware of: _____

List any dietary modifications/restrictions: _____

MEDICATION INFORMATION:

Does your child need to take any prescription medications while participating in team meetings or competitions? Yes No If yes, a mentor will contact you.

Are any of the following used? Inhaler EpiPen None of these are used

If so, does your child have them with them at all times? Yes No

Explain any instructions that are necessary for the medications listed above: _____

My child may be given (If need): Benadryl Ibuprofen Tylenol None

Medical Insurance Information:

Physician: _____ Phone: _____

Physician Address: _____

Insurance Company: _____ Policy #: _____

Policyholder: _____ Relationship: _____

AUTHORIZATION FOR MEDICAL CARE

By signing this form you accept the following:

This health history is correct so far as I know. The person herein described has permission to engage in all activities except as noted. I hereby give permission to the Adult-In-Charge to provide routine first aid care and witness prescribed medications. Should a medical emergency

arise during my child's participation in a Team 1389 sponsored activity, I understand that reasonable efforts will be made to contact the Emergency Contact or my designated Alternate at the phone numbers I have given. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate would cause, I consent to the administration of medical treatment deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances.

This completed form may be photocopied.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature:* _____

Date: _____

*Electronic Signatures Are Not Accepted