Localogy

Jr. Staff Medical History/Consent

Mail To: Localogy
HC 81 Box 41
Questa, NM 87556

Name of Staff member: _____

EMERGENCY CONTACT
Parent #1 Name: _____
Home Phone: (____) _____-_____ Work Phone: (____) _____-_____ Cell: (____) _____-_____
Parent #2 Name: _____
Home Phone: (____) _____-_____ Work Phone: (____) _____-_____ Cell: (____) _____-_____
If parent cannot be reached in an emergency, notify: _____
Home Phone: ( ) - Work Phone: ( ) - Cell: ( ) -

ALLERGIES
Please list all known allergies. Describe allergy (food, medicine, environmental, etc.), reaction to allergen, and management of reaction: _____
_____
_____

☐ **Vegetarian meals** ☐ **Vegan meals** ☐ **Other:**_____

MEDICATION
Please list all medications (including over the counter or nonprescription drugs) taken routinely.

Med #1: _____ Dosage: _____ Specific times taken each day: _____
Reason for Taking: _____
Med #2: _____ Dosage: _____ Specific times taken each day: _____
Reason for Taking : _____
Med #3: _____ Dosage: _____ Specific times taken each day: _____
Reason for Taking: _____
Identify medications taken during the school year that participant does not take during the summer:
_____

INSURANCE
Are you covered by medical/hospital insurance?: ☐ Yes ☐ No
If yes, carrier or plan name: _____ Group #: _____
Please attach a photocopy of health insurance card.

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to Sangre de Cristo Youth Ranch (SCYR) staff to provide routine and emergency health care, and administer prescribed medications. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to SCYR staff to arrange necessary related transportation, and hospitalization for my child. I hereby give permission to the physician(s) selected by SCYR staff to administer necessary treatment, including hospitalization, medications, diagnostic tests, anesthesia, and surgery for my child named above.

Parent/Guardian Signature: _____ Date: ____/____/_____