20may24

2024 Ohio Scottish Arts School - Health Form

Please attach a copy of your child's Medical Insurance card to this form.

Name:____ Birthdate : _______________________

AUTHORIZATION FOR EMERGENCY TREATMENT: I hereby give permission to the medical personnel selected by SACSO, INC., its agents, volunteers, and employees to obtain medical or emergency care for (me/my child) if (I/he/she) become injured or ill during the 2024 Ohio Scottish Arts School. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by SACSO, INC. to secure and administer treatment, including hospitalization, for my child as named above. I agree to reimburse SACSO, INC. for such medical or emergency care.

____ Date: _______________
Participants' Signature (Parent or Guardian if participant is under 18)

I direct that in the event of a medical emergency, I/we be contacted as soon as practical at these phone numbers:

Name: ______________________________________ Day: _________________ Night: _________________

Name: ______________________________________ Day: _________________ Night: _________________

Name: ______________________________________ Day: _________________ Night: _________________

Please PRINT as many different telephone numbers as possible where a family member or friend can be reached in the event of an emergency. Two different day numbers and two different night numbers are important if there is no answer at the first one we try.

I further agree to hold SACSO,INC., its agents, volunteers, and employees harmless for any claims that (I/my child) might have against it for administering any emergency first aid or other medical care.

Health and Medical Information

Do you/your child have any of the following conditions? (please check if YES):

❑ADD/ADHD ❑OCD ❑Behavior Problems ❑Anemia
❑Asthma ❑other Lung Disease
❑Bed Wetting ❑Frequent Urinary Infections ❑Diabetes
❑Ear Infections ❑Tubes in Ears currently
❑Eating Disorders ❑Anorexia/Bulimia ❑Obesity
❑Epilepsy ❑Grand Mal Seizures ❑Absence Spells
❑Hay Fever/Seasonal Allergies ❑Hypertension ❑Heart Disease
❑Mental Health Concerns: ❑Anxiety Disorder ❑Depression ❑Bipolar Disorder
❑Menstrual Concerns
❑Sleep Talking ❑Sleep Walking
❑Sprains, Strains, Muscle, Bone or Joint problems
❑Stomach problems ❑Diarrhea ❑Constipation

Please Explain: ____
____

List and explain any chronic health or physical problems: _______________
____

List any special diet requirements: ________________________________
____

Date of most recent tetanus shot: ________________________________

Allergies:
❑None Known
❑Epi pen usage
❑Insect/Bee Stings
- ❑Serious/Life threatening reaction
- ❑Localized swelling or redness at site

❑Medication Allergies
- ❑Serious/Life threatening reaction
- ❑Hives, rash, diarrhea, other
- ❑Please list Med. Allergies:__________
____
____

❑Food Allergies
- ❑Serious/Life threatening reaction
- ❑Cramps, diarrhea, hives
- ❑Please list Food Allergies:__________
____
____

❑Other Allergies: __________________
____
____

Will any prescription/non-prescription medicine be sent with your child? ❑Yes ❑No
If yes, please complete the Medication Form and bring it with you to check-in.

Physician's name: ____ phone number: ______________________

Dentist's name: ____ phone number: ______________________

Orthodontist's/Specialist's name: __________________________________ phone number: ______________________

In case your child needs the following but did not bring it from home:
Does your child have permission to take cough drops? ❑Yes ❑No
Does your child have permission to take: Tylenol, Ibuprofen or other Aspirin substitute? ❑Yes ❑No