

**EMERGENCY MEDICAL FORM / PERMISSION SLIP / BOY**

**FOR POW WOW 2007**

Name: \_\_\_\_\_

**Outpost#:** \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ ZIP \_\_\_\_\_

Both Parents Names: \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Company/Policy #: \_\_\_\_\_

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**HEALTH HISTORY**

**HAS HE HAD THE FOLLOWING:**

- An attack of appendicitis Yes  No
- Severe Allergies Yes  No
- Asthma or hay fever Yes  No
- Diabetes and/or Insulin Yes  No
- Hernia (rupture) Yes  No
- Rheumatic fever Yes  No
- Scarlet fever Yes  No

**IS HE SUBJECT TO:**

- |                             |                              |                             |
|-----------------------------|------------------------------|-----------------------------|
| Sinus trouble               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Fainting spells             | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Ear trouble                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Convulsions                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Sugar reaction              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Nervousness or easily upset | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Reaction to penicillin      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Poison ivy, oak or sumac    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**IS HE/SHE UNDER MEDICAL CARE WITH MEDICATION**

- Reaction to bee stings Yes  No
- Significant disease, injury/operation: Yes  No
- Is his activity restricted medically Yes  No

**Other Necessary Medical Information**

\_\_\_\_\_  
\_\_\_\_\_

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**PERMISSION FOR EMERGENCY MEDICAL TREATMENT**

In the event: \_\_\_\_\_ becomes ill or sustains injury while in the care of or under the supervision of activity leaders, they are given permission to administer first aid for his relief. Consent is hereby given to admit him to any hospital; consent is also given to any licensed physician and or surgeon called, or to whom our son is taken for treatment by them to administer such treatment, drugs and medicines, and to perform such medical/surgical procedures as he shall deem the existing emergency requires for relief of pain and to preserve his life and health. I hereby agree to reimburse any and all persons and/or facilities for any expenses incurred in the care of my son, should medical treatment be necessary.

I also give my son permission to go to the **NNED DISTRICT POW WOW Camping Trip in Effingham, New Hampshire on August (16), 17, 18 and 19, 2007.**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Parent/Guardian

**Phone number where you may be reached in case of emergency during the above dates:**  
( \_\_\_\_\_ ) \_\_\_\_\_

**EMERGENCY MEDICAL FORM / ADULT**  
**FOR POW WOW 2007**

Name: \_\_\_\_\_

**Outpost#:** \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ ZIP \_\_\_\_\_

Name of closest relative: \_\_\_\_\_ Relationship \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Company/Policy #: \_\_\_\_\_

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**HEALTH HISTORY**

**HAS HE/SHE HAD THE FOLLOWING:**

- An attack of appendicitis    Yes  No
- Severe Allergies                Yes  No
- Asthma or hay fever            Yes  No
- Diabetes and/or Insulin        Yes  No
- Hernia (rupture)                Yes  No
- Rheumatic fever                Yes  No
- Scarlet fever                    Yes  No

**IS HE/SHE SUBJECT TO:**

- Sinus trouble                    Yes  No
- Fainting spells                 Yes  No
- Ear trouble                      Yes  No
- Convulsions                    Yes  No
- Sugar reaction                 Yes  No
- Nervousness or easily upset Yes  No
- Reaction to penicillin        Yes  No
- Poison ivy, oak or sumac    Yes  No

**IS HE/SHE UNDER MEDICAL CARE WITH MEDICATION**

- Reaction to bee stings            Yes  No
- Significant disease, injury/operation:    Yes  No
- Is his/her activity restricted medically    Yes  No

**Other Necessary Medical Information**

\_\_\_\_\_  
 \_\_\_\_\_

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**PERMISSION FOR EMERGENCY MEDICAL TREATMENT**

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Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**Phone number where closest relative may be reached in case of emergency:**

( \_\_\_\_\_ ) \_\_\_\_\_