



HEALTH & MEDICAL / EMERGENCY CONTACT

HEALTH & MEDICAL INFORMATION MUST BE FILLED OUT FOR EACH MEMBER (CHILD).

The intent of this information is to provide staff the background to communicate important health history information in the event of an emergency. Martial Arts USA recommends that each child visit a physician and undergo a physical prior to camp enrollment to ensure good health.

Martial Arts USA discourages the consumption of medication during program hours. If possible medication should be administered to the member before or after program hours. If medication must be administered during program hours this form must be completed. Note the following:

1. Medication must be in their original container and contain name of prescribing physician
2. Responsible Party/Buyer is responsible for submitting the new Medication Authorization Form each time there is a change in dosage, dosage time or frequency.
3. Martial Arts USA does not assume responsibility for unauthorized medication taken independently by the member during program hours.
4. Medication may not be accepted by a Martial Arts USA representative without the completion of this form.

Member/Child 1 Name: _____ DOB: ____ / ____ / ____

List known allergies and reactions (check none if none): None

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Medications being taken (check none if none): None

Please list ALL medications (including over the counter and nonprescription drugs) taken routinely. If Martial Arts USA must administer medication you must complete a Medication Authorization Form when you provide the medication.

Med 1: _____ Med 2: _____

Med 3: _____ Med 4: _____

Restrictions (check none if none): None

Please list any restrictions to activity, diet, or other: _____

Other information (check none if none): None

Please describe any behavioral, physical, emotional, or mental health issues that Martial Arts USA need to be aware of: _____

Member / Child 1				
Med Name:				
Med Type:	<input type="radio"/> Over-The-Counter <input type="radio"/> Prescription			
Med Usage:	<input type="radio"/> Taken Regularly <input type="radio"/> As Needed			
If taken as needed (e.g. allergies, head aches, etc.) Please describe symptoms and/or circumstances.				
Dosage amount:				
Dosage times: (if taken as needed symptoms and/or circumstances must be listed above)				

Member/Child 1 Name: _____ DOB: ____ / ____ / ____

List known allergies and reactions (check none if none): None

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Medications being taken (check none if none): None

Please list ALL medications (including over the counter and nonprescription drugs) taken routinely. If Martial Arts USA must administer medication you must complete a Medication Authorization Form when you provide the medication.

Med 1: _____ Med 2: _____

Med 3: _____ Med 4: _____

Restrictions (check none if none): None

Please list any restrictions to activity, diet, or other: _____

Other information (check none if none): None

Please describe any behavioral, physical, emotional, or mental health issues that Martial Arts USA need to be aware of: _____

Member / Child 2				
Med Name:				
Med Type:	<input type="radio"/> Over-The-Counter <input type="radio"/> Prescription			
Med Usage:	<input type="radio"/> Taken Regularly <input type="radio"/> As Needed			
If taken as needed (e.g. allergies, head aches, etc.) Please describe symptoms and/or circumstances.				
Dosage amount:				
Dosage times: (if taken as needed symptoms and/or circumstances must be listed above)				