



# 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				
<b>Med Name:</b>				
<b>Med Type:</b>	<input type="radio"/> Over-The-Counter <input type="radio"/> Prescription	<input type="radio"/> Over-The-Counter <input type="radio"/> Prescription	<input type="radio"/> Over-The-Counter <input type="radio"/> Prescription	<input type="radio"/> Over-The-Counter <input type="radio"/> Prescription
<b>Med Usage:</b>	<input type="radio"/> Taken Regularly <input type="radio"/> As Needed	<input type="radio"/> Taken Regularly <input type="radio"/> As Needed	<input type="radio"/> Taken Regularly <input type="radio"/> As Needed	<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				
<b>Med Name:</b>				
<b>Med Type:</b>	<input type="radio"/> Over-The-Counter <input type="radio"/> Prescription	<input type="radio"/> Over-The-Counter <input type="radio"/> Prescription	<input type="radio"/> Over-The-Counter <input type="radio"/> Prescription	<input type="radio"/> Over-The-Counter <input type="radio"/> Prescription
<b>Med Usage:</b>	<input type="radio"/> Taken Regularly <input type="radio"/> As Needed	<input type="radio"/> Taken Regularly <input type="radio"/> As Needed	<input type="radio"/> Taken Regularly <input type="radio"/> As Needed	<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)				