PARTICIPANT HEALTH FORM

PART I. TO BE COMPLETED BY LICENSED PHYSICIAN

Child's Last Name Child's First Name

Allergens Identified:

Symptoms:

_____ Shortness of breath or difficulty in breathing

_____ Swelling of face or lips

_____ Other: (explain)

_____ Hives

_____ Vomiting

_____ Diarrhea

_____ Do not administer medication in the absence of known exposure to allergen.

Explain:

Procedures:

Please indicate all steps necessary and the order in which they should be taken.

_____ Administer Medication (specify)

_____

_____

_____

_____ Call the area's emergency medical personnel (e.g. 911)

_____ Call parent(s)/guardian(s)

_____ Other

Explain:

_____

_____

Name of the medications(s):

_____

_____

Diagnosis/purpose of medication(s):

_____

_____

Dosage prescribed:

_____

_____

Time schedule:

Dosage form (tablet, liquid, EpiPen, etc.)

Date of prescriptions(s):

Precise method of administering the medication

Length of time medication will be necessary:

Possible side effects:

Action to be taken in case of side effects:

Storage instructions: Medication shall be stored in student's carrying case, as specified to staff in writing.

Special instructions:

_____

_____

_____

_____

I verify that this student is under my care and requires this medication.

_____	_____
Physicians Printed Name	Physician's Signature
_____	_____
Date	Phone Number

_____

Street Address City State Zip Code

PART II. TO BE COMPLETED BY PARENT(S)/GUARDIAN(S)

Participant's Last Name	Participant's First Name

Gender	Date of Birth	Program Site

The above named participant is required to take medication prescribed by a licensed physician during the CAP Program or may require such medication if the identified symptoms are exhibited. I request that designated CAP personnel administer medication to my child in accordance with the instructions provided by the physician.

By signing this form, I/we authorize CAP to follow the above instructions in the Health Form. I/we agree to update this form every six months or sooner if my/our child's needs change.

Parent/Guardian Name:_____

Address:_____

Telephone Number:_____

Emergency Contact Number:_____

Parent/Guardian Signature	Date

Parent/Guardian:_____

Address:_____

Telephone Number:_____

Emergency Contact Number:_____

Parent/Guardian Signature	Date