Medical Authorization Form

Student Name:_____
Last First Initial

Student's Primary Residence:

_____ _____
Number Street Home Phone

_____
City State ZIP

Parent/Guradian Name:_____ _____
Home Phone/Work Phone/Cell Phone

Second Guradian Name:_____ _____
Home Phone/Work Phone/Cell Phone

Parent Guardian Home Address: (If different from above)

_____ _____
Number Street Home Phone

_____
City State ZIP

If parents/or primary guardians are not available in an emergency, please contact:

Name:_____ _____ _____
Relationship Phone

Address:_____
Number Street City State

We carry personal accident and/or health insurance

Name of Subscriber: _____ Please attach a photocopy
Name of Company: _____ of both sides of your
Policy Number: _____ insurance card.

Please indicate which of the following medications may be given to the above named student

Tylenol _____ Ibuprofen(Advil)_____ Decongestant _____ Antihistamine_____
Dramamine_____ Pepto Bismol _____ Anti-diarrheal_____ Cough Drops or HALLS _____

To be completed by parent/legal guardian and signed in front of a raised seal notary

I hereby give my consent for the above named student to engage in HVS FIRST Club activities and to accompany the team on its trips. The school is not liable for injuries or the cost of medical care resulting from any injuries.

In the event I cannot be reached in an emergency, I hereby authorize a HOT team mentor to seek reasonable medical treatment, including hospitalization, for my child as named above. I also authorize release of treatment information to the proper insurance company for payment purposes.

I also give my permission for my student to be interviewed/photographed by the media in relation to their participation in the FIRST Robotics Competition and HOT Team membership.

Parent Signature _____
Date _____

Notarized By _____
Date _____

Embossed (Raised) Seal Imprint
Needed for all out of state trips that may be taken during the school year

Physical Form

Student Name _____

Birth Date _____ Sex _____ Year of Graduation_____

Health History

Parent, please place a check mark next to any chronic conditions that apply to your child.

ADHD		Earache/infections		Hypoglycemia	
Allergies		Fainting		Intestinal pain	
Arthritis		Chronic Fatigue		Joint/bone pain	
Asthma		Glasses/contacts		Mononucleosis	
ASD		Hay fever		Muscle weakness	
Bleeding Clotting Disorder		Head injury		Nausea	
Chest pain		Headache		Shortness of breath	
Convulsions / Epilepsy		Hearing problems		Stomachache	
Diabetes		Heart defect		Urinary Tract Disorder	
Diarrhea/ IBS/Crohns		Hypertension		Vision problems	

List other chronic conditions:

Date of last tetanus shot _____

List any long term medications. Note medical instructions. Add any pertinent information.

_____

_____

_____

List any food, medication or environmental allergies.

_____

_____

_____

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Physician Statement

This section is to be completed and signed by a physician.

☐ This student's immunizations are up to date

☐ This student's health (also considering long term medications) is satisfactory. There is no medical condition (like impaired cognition, coordination, fainting…) that would put this student in danger if he or she is in proximity to or using heavy machinery with proper instruction and supervision.

Health conditions that the supervisors of this activity should be made aware of. (attach additional comments if necessary)

_____

I certify that I have on this date examined the above student and recommend him/her as being physically able to participate in FIRST activities.
For more details on this activity see www.usfirst.org

Physician Signature _____ Date _____

Physician's Address _____Bldg

_____

_____

Telephone Number _____