Rotary Youth Leadership Program
Medical History Form

All medical information will be kept strictly confidential.

The following **must be** completed by the parent/guardian of the Delegate and **submitted** to Daniel Crupi, RYLP Program Director **by Friday, May 26, 2017** at dcrupi@greensborosymphony.org.

Participant Name _____

Primary Contact Name _____

Address _____

City_____State_____Zip_____

Phone number (H)_____ (W)_____ (C)_____

Secondary Contact Name _____

Address _____

City_____State_____Zip_____

Phone number (H)_____ (W)_____ (C) _____

Does your child have any medical conditions that the Program Team should be aware of such as asthma, allergies (bee sting, plants, medications, etc.), epilepsy, rheumatic fever, diabetes, or physical impairment of any kind?
If **no**, write "none" _____
If **yes**, please specify:

Does your child have any physical limitations that may restrict participation in program activities?
If **no**, write "none" _____
If **yes**, please specify:

Has your child been exposed to any contagious diseases in the last 6 months?
If **no**, write "none" _____
If **yes**, please specify:

Will your child be taking any required or prescription medication during the Rotary Youth Leadership Program?
If **no**, write "none" _____
If **yes**, please specify the medication and the reason for taking:

My child may be given the following medications by the RYLP Program Team to alleviate common aches and pains:
If **no**, write "none" _____
If **yes**, please specify:

- ☐ Tylenol (acetaminophen)
- ☐ Aspirin
- ☐ Advil (ibuprofen)
- ☐ Benadryl

Does your child have any special dietary needs or food allergies?
If **no**, write "none" _____
If **yes**, please specify:

In the event of an accident or illness that requires medical care, I hereby authorize and request the RYLP Program Director and staff to obtain medical treatment or hospitalization as may be necessary and I authorize the treatment facility to perform such emergency injections, anesthesia or surgery as may be necessary. I realize that the costs for these medical services are my responsibility and not those of the Rotary Youth Leadership Program or its staff.

Parent/Guardian name (printed) _____

Parent/Guardian signature _____

Date _____