

MWSC HEALTH FORM

Name of participant _____

Name of primary care physician: _____

Health Insurance and policy number: _____

Parents/Guardians names and emergency phone numbers: _____

Please circle correctly

Environmental allergies: No Yes, please specify

Food Allergies No Yes, please specify

Allergies to medication No Yes, please specify

Asthma? No Yes, please specify inhaler

Regular medication? No Yes, please specify

Medical or health concerns? No Yes, please specify

Participant Signature

Date

For participants under age 18:

Parent/Guardian full name (in print)

Parent/Guardian signature

Date