



# C.M. Four Winds Stable Youth Medical Care and Treatment Form

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name of Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Family Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

If you or the doctor cannot be contacted, in emergency notify:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Tetanus Immunization: Date of Last Booster** \_\_\_\_\_

### Medication Procedures

1. All prescription drugs MUST be carried in the container in which they were issued (with medical orders and physician's name intact). Others will not be accepted.
2. Only the exact amount of medication for the length of the event should be brought to CM's programs and should be kept in the possession of a responsible adult during the program.

### CIRCLE BELOW IF PARTICIPANT IS SUBJECT TO ANY OF THE FOLLOWING CONDITIONS:

arthritis, asthma/respiratory problems, bladder disease, bronchitis, convulsions, diabetes, ear infection, frequent headaches, heart trouble, home sickness, intestinal problems, kidney disease, fainting, seizures, sleepwalking, stomach problems allergies (please list) \_\_\_\_\_

other (please specify) \_\_\_\_\_

### PRESCRIBED TREATMENT – List any medications that you take. Include prescription *and* non-prescription (such as pain relievers aspirin, Tylenol, asthma inhaler, etc.) PLEASE INCLUDE DOSAGES AND ANY SPECIAL INSTRUCTIONS:

\_\_\_\_\_  
\_\_\_\_\_

My child can hold on to and administer his/her own medication. YES NO \_\_\_\_\_

signature of parent/guardian

A staff member/chaperone may administer Benedryl, Tylenol or Motrin (acetaminophen or ibuprofen) YES NO

### LIST APPROXIMATE DATE IF PARTICIPANT HAS HAD OR BEEN EXPOSED TO OR SUFFERING FROM A RECENT ILLNESS OR INJURY; Operations or Serious Injuries requiring medical treatment (specify on another piece of paper if you need to.)

USE OTHER SIDE IF NECESSARY.

My child is physically able to participate in this program including handling their project animals, if animals are involved; and in the case of the CM's horse project, participating in mounted activities. I understand that the CM members will be supervised, and that if a serious illness or injury develops, medical and/or hospital care will be given; however, the sponsor is not responsible in case of accident or illness. I further understand that in case of medical emergency we will be notified. In the event that I cannot be reached, I hereby give permission to the attending physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my child as named on this Medical Care and Treatment Form and do certify that the information set forth on this form is true and correct to the best of my knowledge. I will assume all financial obligation incurred if not covered by insurance.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Event: \_\_\_\_\_ Event Date \_\_\_\_\_