HEALTH HISTORY & TREATMENT AUTHORIZATION FOR ALL PEROSN UNDER THE AGE OF 18

Circle: Male/ Female

Child Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child Grade SEPT 2021:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY Parental/LEGAL GUARDIA NAME(S):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALRENATIVE EMERGENCY CONTACT NOT LISTED ABOVE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO CHILD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILDS PRIMARY DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILDS HEALTH INSURANCE CARRIER AND STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GROUP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY/MEMBER ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILDS MEDICATIONS CURRENTLY TAKEN WITH DOSAGE AND REASON: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

KNOW ALLERGIES/ REACTIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOES YOUR CHILD CARRY AN EPI-PEN, INHALER OR EMERGENCY BENADRYL? Circle YES/ NO

Does your child have the ability and to self-administer the above medications listed above?

Circle: YES/ NO [ PARENT/ GUARDIAN SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_

I CERTIFY THAT ALL INFORMATION PROVIDED ON THIS FORM IS COMPLETE, TRUE, AND ACCURATE TO THE

BEST OF MY KNOWLEDGE.IN THE EVENT OF A MEDICAL EMERGENCY, I HEREBY AUTHORIZE HOOP GROUP

AND ITS REPRESENTATIVES TO TREAT AND/OR TRANSPORT THE CHILD TO THE CLOSEST HOSPITAL OR

URGENT CARE FACILITY AND AUTHORIZE ANY TREATMENT DEEMED MEDICALLY NECESSARY BY THE ATTENDING PHYSICIAN. I ALSO AUTHORIZE THE PHYSICIAN OR HOSPITAL TO RELEASE THE CHILD AFTER TREATMENT TO A REPRESENTATIVE OF HOOP GROUP.

PARENT/LEGAL GUARDIAN SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_