2010 Cast Member Medical Information Form

Full Name: ____
First   Middle   Last

Date of Birth: ______________________ ☐ Male ☐ Female

Mailing Address: ____

Home Phone: ____

Medical History

List any medical conditions, illnesses, traumatic injuries, or physical disabilities or limitations

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Do you wear a medical alert bracelet? ______________ Where: ______________

Date of Hepatitis Vaccination completion: ______________

Date of last Tetanus shot: ______________

Allergies

List all allergies i.e. to medicines, insect bites, foods, pollens, dust, sun, latex, etc.

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Medications

List any medications and their dosages, including over-the-counter medications, which are taken either on a regular/daily or as needed basis

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My son/daughter/or I make take TYLENOL/IBUPROFEN/BENADRYL/TUMS (circle your choices) as requested and approved by our First Aid personnel.

-OVER-

Other

Is there any information not included above that would be helpful to know so that we may make you/your child's work experience as successful as possible? Ex. (Difficulty with certain tasks, etc).

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Contacts

Parents/Guardians/Spouse	*Relationship*	*Daytime Phone #*
1.		
2.		

In Case of Emergency	*Relationship*	*Daytime Phone #*
1.		
2.		

Family Physician: ______________________ *Phone:* ______________

I hereby give permission for my child/self to receive first aid as needed at Story Land and to be transported to The Memorial Hospital (TMH) in North Conway for further treatment if necessary. I understand that information on this form may be shared with pre-hospital personnel and/or TMH as necessary. Any information provided on this form will be kept in strictest confidence.

Please Sign ______________________________ Date ___/___/_____

Parent/Guardian must sign if cast member is under 18 years old