ChildVoice

Medical Disclosure and Treatment Form

To better serve you in the case of an emergency during your trip (activity), ChildVoice requires the following information. This information will be kept confidential and only given to staff as necessary. At the end of your trip this information will be destroyed. In the case of a medical emergency this information would be given to medical personnel treating you. Please fill out the section below and read and sign the statement at the bottom of the form.

Participant's Name (print) _____

Address _____

City _____ State _____

Age (if under 18): _____ Destination _____

Dates of activity _____

Please list all of the following and explain any steps that should be taken to address the situation (E.G. if stung by a bee, administer epi pen).

Medication Allergies:

_____

_____

_____

_____

Food and Other Allergies:

_____

_____

_____

_____

Physical Impairments:

_____
_____
_____
_____

Chronic Illnesses/Medical Problems:

Illness/Problem Treatment Date

_____
_____
_____
_____
_____
_____

Are you presently under a physician's care for any illness or condition?

Yes No (circle one) If yes, please explain:

_____
_____
_____
_____
_____

Have you been hospitalized more than two times for a single condition?

Yes No (circle one) If yes, please explain:

_____
_____
_____
_____
_____
_____

Please list all medications (prescription and over the counter) you are currently taking:

Medication Reason

_____
_____
_____
_____
_____
_____
_____

Immunizations: Please attach a print out of your current immunizations

Current Doctor:

Name _____

Phone Number _____ Email _____

Have you ever sought counseling or psychological treatment of any type?

Yes No (circle one) If yes, please explain:

_____
_____
_____
_____
_____

Have you ever had a problem with drugs or alcohol?

Yes No (circle one) If yes, please explain:

_____
_____
_____
_____

Please provide any details pertaining to your health not covered by the above questions.

_____
_____
_____
_____
_____

I (print name) _____ agree to the release of the above information to ChildVoice International for use during the above listed dates. I understand that this information will be kept confidential, only released to necessary staff as needed, and destroyed at the end of the trip.

I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company.

In the event of an emergency I hereby give permission to the medical personnel selected by ChildVoice International, their designee or the participant's team leader(s) to order X-rays, routine test, to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery for myself or my child as named above.

This health history is accurate and complete, so far as I know.

Signature: _____

Date: _____

If the participant is under the age of 18:

Parent/Guardian

Relationship: _____

Name (print): _____

Signature: _____

Date: _____