



**SONOMA VALLEY**  
**TEEN SERVICES**  
Engaging ♦ Connecting ♦ Empowering

**Medical Form**  
CONFIDENTIAL

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Gaurdian: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Cell Phone/Work Phone: \_\_\_\_\_

In case of emergency please contact the following person(s) who will be available in the event that I may not be able to be contacted:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Any physical or behavioral conditions that could limit your child or cause any potential danger to him/her?  
\_\_\_\_\_

Any special diet/food allergies? \_\_\_\_\_

Date of last tetanus shot? \_\_\_\_\_ Allergies? \_\_\_\_\_

Allergies to penicillin or any other medication? \_\_\_\_\_

Asthma? \_\_\_\_\_

Bee sting/shellfish or any other serious allergy? \_\_\_\_\_

Does your child carry any medications such as inhalers or emergency allergy injection kits? If so what? \_\_\_\_\_

Does your child carry/administer his/herself? YES/NO

Can staff administer any of the following medications to your child in the event of illness or minor injury?

Tylenol	YES/NO
Ibuprofen	YES/NO
Benadryl	YES/NO
Neosporin	YES/NO
Antacid	YES/NO
Cough/Cold (Non-alcoholic)	YES/NO

In case of emergency I authorize the emergency room physician, paramedics, or other physician to provide care for my child. I also give permission for Sonoma Valley Teen Services (SVTS) staff to act on my behalf until I arrive. I understand that in the event of an emergency SVTS staff will provide immediate care/comfort to my child and make every effort possible to contact me immediately.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_