



**\*\*PLEASE PRINT FORM AS A DOUBLE-SIDED, SINGLE SHEET OF PAPER\*\***

Conditions or physical limitations not previously mentioned:

Allergies (drug, food, environmental)

1. \_\_\_\_\_ Reaction: \_\_\_\_\_
2. \_\_\_\_\_ Reaction: \_\_\_\_\_
3. \_\_\_\_\_ Reaction: \_\_\_\_\_

Current Prescription Medications/Inhalers (including those only taken as needed)

1. \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_
2. \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_
3. \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_
4. \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

**\*\*\*YOU MUST BRING ALL MEDICATIONS AND INHALERS WITH YOU, EVEN IF YOU TAKE THEM ONLY ON AN AS NEEDED BASIS!\*\*\***

Surgical History (include date):

Primary Care Provider Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Consent for Treatment**

I, \_\_\_\_\_, parent/legal guardian of \_\_\_\_\_ certify this attendee is in good physical condition and give permission for her to receive any and all emergency treatment deemed necessary by medical personnel during ALA VGS in case of accident or illness. I also grant permission for minor treatment and/or administration of over the counter medications (e.g. Tylenol, antacids, throat lozenges) by the ALA VGS Staff, nurse practitioner/registered nurse on staff, and/or infirmary staff on the Lipscomb University campus.

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

**Insurance Information**

Policy Holder Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Provider (Company): \_\_\_\_\_

Plan #: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Please attach a copy of the front/back of your insurance card to this form

You will NOT have access to copier at registration

Check here if not insured