



## Participant Insurance/Medical Information

This information is necessary to have on file in the event your child should suddenly become ill. Please feel free to attach a separate sheet of paper listing any additional information that you feel would be helpful to the staff and/or medical personnel working with your child.

Height	Weight	Eye Color	Hair Color	Race
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Physician's Name (required)	Phone (required)
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Insurance Coverage	Group #	Phone
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Name of Insured	Relationship
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Hospital of Choice
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Does your child have any **ALLERGIES** or **MEDICAL CONDITIONS** that should be considered?  Yes  No  
If yes, please specify.

Are there any **SPECIAL INSTRUCTIONS** or **RESTRICTIONS** from you or the child's doctor?  Yes  No  
If yes, please specify:

### Routine Medications

The participant takes medications on a routine basis:  Yes  No

Please attach a list of ALL medications, prescription and non-prescription, taken on a routine basis and give the reason why the medication is taken. Backfield in Motion prefers that all medications be administered at home. However, if it is necessary, please send enough medication to last for the entire session. Keep it in the original packaging that identifies the prescribing physician (prescription drugs only), the name of the medication, the dosage, and the frequency of administration.

### Medical History

Please place a check by ALL conditions that may apply to your child in each section.

- |   |  |
|---|--|
| <input type="checkbox"/> Ever had a reaction to a TB skin test                    | <input type="checkbox"/> Ever had surgery                                  |
| <input type="checkbox"/> Been with anyone having TB                               | <input type="checkbox"/> Any recent injury, illness, or infectious disease |
| <input type="checkbox"/> Ever been hospitalized                                   | <input type="checkbox"/> Chronic or recurring illness or condition         |
| <input type="checkbox"/> Ever had an emotional or psychological difficulty for w/ |  |

Which of the following has your child had?

- |   |   |
|---|---|
| <input type="checkbox"/> Measles        | <input type="checkbox"/> Mumps            |
| <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Hepatitis        |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Varicella Zoster |

My child's immunization records are on file at: \_\_\_\_\_ School and are up to date.

Date of Last Doctor's Visit (month/year)	Physician's Name
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### Head/Chest

Please place a check by ALL conditions that may apply to your child.

- |   |   |
|---|---|
| <input type="checkbox"/> Frequent Headaches                         | <input type="checkbox"/> Has tubes in ears                            |
| <input type="checkbox"/> Ever had a head in jury                    | <input type="checkbox"/> Ever passed out during or after exercise     |
| <input type="checkbox"/> Been knocked unconscious                   | <input type="checkbox"/> Ever been dizzy during or after exercise     |
| <input type="checkbox"/> Frequent Ear Infections                    | <input type="checkbox"/> Ever had chest pain during or after exercise |
| <input type="checkbox"/> Ever had seizures, fits, or shaking spells |   |

### Diagnosed Conditions

Please place a check by ALL conditions that may apply to your child.

- |  |  |
|--|--|
| <input type="checkbox"/> Ever had high blood pressure            | <input type="checkbox"/> Had problems with diarrhea/constipation |
| <input type="checkbox"/> Ever been diagnosed with a heart murmur | <input type="checkbox"/> Have any skin problems                  |
| <input type="checkbox"/> Ever been diagnosed with diabetes       | <input type="checkbox"/> Ever had a bladder or kidney infection  |
| <input type="checkbox"/> Ever been diagnosed with asthma         | <input type="checkbox"/> ADD or ADHD (circle one)                |

### Special Characteristics or Conditions

Please place a check by ALL conditions that may apply to your child.

- |  |  |
|--|--|
| <input type="checkbox"/> Any problems with speech  | <input type="checkbox"/> Has an eating disorder    |
| <input type="checkbox"/> Any problems with vision  | <input type="checkbox"/> Any reactions to medicine |
| <input type="checkbox"/> Any problems with hearing | <input type="checkbox"/> Any reaction to DPT       |
| <input type="checkbox"/> Has allergies             | <input type="checkbox"/> Any reactions to insects  |

# Statement of Understanding, Permission, & Waiver

After reading, please place a check mark in the box beside each statement.

- My child has permission to participate in all Backfield in Motion activities, including field trips and transportation, where applicable.
- The health history provided is correct as far as I know, and my child named above has permission to engage in all activities except as noted.
- I understand that my child is solely responsible for his/her actions. Therefore, if actions warrant, and my child's behavior is not acceptable (according to Backfield in Motion's guidelines), I understand that my child may be sent home at any time and at my expense.
- I grant permission for photographs, written/art work, quotes, videos, or other media which may include my child, to be used in media releases that benefit Backfield in Motion.
- In the event of an emergency, I hereby give permission to the physician selected by Backfield in Motion to order x-rays, routine tests, and treatment for the health of my child. In the event that I cannot be reached in an emergency, I give permission to the physician selected by Backfield in Motion to secure proper treatment for, hospitalize, and/or to order injections, anesthesia, or surgery, if necessary.
- In the event it becomes necessary for Backfield in Motion staff to give consent for us, we agree to hold such person and Backfield in Motion free and harmless of any claims, demands, or suits for damages arising from the giving of such consent so long as the treatment is administered by or under the supervision of a licensed physician.
- By signing this form, I expressly assume the risk of damage or harm to person or property.
- I understand that I can not hold Backfield in Motion nor any of its agents, employees, volunteers, or invitees liable to me or any of my family, agents, employees, volunteers, servants, or invitees for any damage to persons or property when and to the extent that any such damage or injury may be caused, either proximately or remotely, wholly or in part, by any act or omission, whether negligent or not, of Backfield in Motion nor any of its agents, employees, volunteers, or invitees or due to the condition, design, or defect in the building, its mechanical systems, or its equipment.
- I give Backfield in Motion consent to obtain any and all school records to help monitor and track my child's academic progress. All rights of privacy will be maintained and all records will be kept confidential and in full legal compliance. Only Backfield in Motion staff will have access to and utilize the information obtained therein. This information may also be used to monitor and track the success of the program.
- I have read, understand, and agree to the Backfield in Motion Statement of Understanding, Permission, and Waiver.

Signature of Parent/Guardian

Printed Name of Parent/Guardian

Date