116TH PENNSYLVANIA VOLUNTEER INFANTRY, COMPANY B
4TH CALIFORNIA VOLUNTEER INFANTRY, COMPANY D

MINOR MEDICAL RELEASE AND EMERGENCY CONTACT FORM

I, _____ being the parent or legal guardian having legal custody of the minor child or children named below, authorize the performance of all medical, surgical, diagnostic, and hospital care, procedures or treatment, which may be performed or prescribed for the minor child or children by a licensed physician or hospital, when reasonable efforts to timely contact me are unsuccessful and when such care or procedures are deemed immediately necessary or advisable by the physician to safeguard the minor child's or children's health. I hereby waive my right of informed consent to such care, procedures or treatment for:

Name _____ Date of birth _____ Male ☐ Female ☐
Name _____ Date of birth _____ Male ☐ Female ☐
Name _____ Date of birth _____ Male ☐ Female ☐
Address _____
City _____ State _____ Zip _____ Phone No. _____

In case of emergency, notify:

Name _____ Relationship _____
Address _____
Home phone _____ Work phone _____ Cell phone _____
Alternate contact _____ Alternate's phone _____
Physician's Name _____ Physician's Phone No. _____

Signature(s) of Custodial Parent(s) or Legal Guardian(s):

X _____ X _____
Parent ☐ Legal Guardian ☐ Print name

X _____ X _____
Parent ☐ Legal Guardian ☐ Print name

ALLERGIES

Does your child have known allergies? Yes ☐ No ☐

If yes, please list all known allergies, including medication, food, plants, or insect bites, and indicate severity, below:

_____
_____
_____
_____

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HEALTH HISTORY

Is the child now, or has he/she ever been treated for any of the following:

Yes	No	Condition	Explain
		Asthma Uses Inhaler: Yes ☐ No ☐	
		Diabetes Last HbA1c:	
		Hypertension (high blood pressure)	
		Heart disease (e.g. CHF, CAD, MI)	
		Stroke/TIA	
		Lung/respiratory disease	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Behavioral disorders (e.g. ADD, ADHD, Asperger syndrome, autism)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures Last seizure:	
		Sleep disorders (.e.g., sleep apnea)	Use CPAP: Yes ☐ No ☐
		Abdominal/digestive problems	
		Surgery	
		Serious injury	
		Other	

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication _____ Strength _____Frequency _____ Approx. date started _____ Reason for medication _____ _____	Medication _____ Strength _____Frequency _____ Approx. date started _____ Reason for medication _____ _____	Medication _____ Strength _____Frequency _____ Approx. date started _____ Reason for medication _____ _____