Evolution Medical Information Sheet and Consent Form

Parents
Names:____

Address ________________________________ Phone Number (_____) _____ - ________

Members Name __________________________ Birth Date ______/________/___________

Family Doctor ___________________________ Phone Number (_____) _____- _________

Physical Condition (Answer "Yes" or "No")

Allergies ________ Asthma ______ Diabetes ______ Epilepsy ______

Tuberculosis ______ Seizures ______ Headaches ______ Hemophilia ______

Rheumatic Fever ______ Kidney Problems ______ Motion Sickness ______

Vision Problems ______ Hearing Problems ______ Bone/Muscle Defect ______

Heart Problems ______ High Blood Pressure ______

Other Problems?
____

In the last twelve (12) months has your child had:

Surgery ______ Serious Illness ______ Serious Accident ______

Skull Fracture ______ Diagnosed Concussion ______

Comments: ____

Is your child taking any medications ______ Specify:
____

____

Is your child allergic to any medications ______ Specify:
____

____

Is your child allergic to any foods or drink _____ Specify:
____

____

I ___________________________________, declare that I am the father/mother/guardian of _____________________, a minor child, age ____, born _________, 19__, am the guardian and have legal custody of said child who resides with me. I, authorize the instructors, directors, and/or chaperones, in whose care the minor has been entrusted and who are associated with Evolution, to consent to any x-ray examination, anesthetic, medical and/or surgical or treatment, and hospital care to be rendered to the minor under general or special supervision and on the advice of any physician, surgeon, or dentist licensed to practice in the state where the event occurs which give rise to the need to operate under this consent. The undersigned further releases and discharges Evolution and the above representative and/or employees of Evolution, their representatives and/or employees acting in good faith under the terms of this consent considering the conditions then and there existing causing them to act under this authorization and consent.

Dated in the City of Sheboygan, State of Wisconsin, this _____day of ______________, 20______

___________________________ ____________________________
Consenting Parent or Guardian Witness (you must have a witness signature)

(This consent is valid until the first day of the next fiscal year, which begins November 1, 2006)