Marlin Fitzwater
CENTER FOR COMMUNICATION

The Presidency and The Press: July 17-21, 2023 Medical Form

The Marlin Fitzwater Center for Communication

(Please type or print legibly)

Dear Participant:
For our records, and for your protection, please complete this form in its entirety. Please provide ALL requested information and obtain the signature of your parent or legal guardian.

PERSONAL INFORMATION

Last name First name Middle initial

Gender Date of birth Place of birth

Area code Telephone number High school /Institution you represent

Your permanent street address

City State Zip code

EMERGENCY CONTACT INFORMATION

Last name **First name** **Relationship to student / participant**

(area code) Primary telephone number **(area code) Secondary telephone number**

Name of family physician **(area code) Physician telephone number**

PERSONAL MEDICAL HISTORY

Please check the following diseases you had in the past:

D Bleeding Tendencies	D German Measles	D Polio
D Chicken Pox	D Heart Disease	D Pneumonia
D Diphtheria	D Measles	D Rheumatic Fever
D Diabetes	D Mononucleosis	D Tonsilitis
D Epilepsy	D Mumps	

Check the following Conditions you have had or are subject to now:

Asthma	D	Nose Bleed	D	Dizzy Spells	D
Ear Infection	D	Hearing Loss	D	Fainting Spells	D
Hay Fever	D	Vision Loss	D	Difficulty Sleeping	D
Headache	D	Upset stomach	D		
Migraine	D	Convulsions	D		

What treatments or medications (if any) do you require for any of the above conditions?

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Are there any past hospitalizations or illnesses we should be aware of?

Please list all allergies (insect stings, plants, foods, etc)

Please list any dietary needs:

MEDICATION

Please list any medications you have allergic reactions to (penicillin,sulfa drugs, tetnus antioxin, etc):

Please list any medications you are taking, including: (1) name and type of medication; (2) condition for which medication is being prescribed; and (3) dosage information. By signing this form, you attest that the use of the medication will not impair the participant's ability to care for his/her own safety or the safety of others; increase the risk of harm to others; or cause dizziness and/or fatigue.

Insurance Information

Insurance Company: _____

Insurance Policy Number: _____

Insurance Company Phone number _____

Please attach a copy of the student's medical insurance card.

GENERAL

If there are any limitations on the amount of physical exercise you can engage in, please describe and explain (use additional sheet of paper if necessary):

I verify that all information provided in this Medical History Records Form is complete and accurate. I hereby give my permission to Franklin Pierce University to store the above prescription medication listed to my child and any over-the-counter medication that I request. I understand that all FRANKLIN PIERCE staff, volunteers and FRANKLIN PIERCE, as an organization, are not liable for any adverse affects that may occur due to this medication and they are not liable in the possibility that a child misses a prescribed dose or in the event the medication is administered incorrectly. I also state that all the above information is complete and accurate and any misapplication of medication due to inaccurate, incomplete, or unreadable information is not the responsibility of FRANKLIN PIERCE. I also understand that the FRANKLIN PIERCE staff, volunteers and FRANKLIN PIERCE, as an organization, are not responsible if my child fails to present themselves at the announced places/times to take the above specified medication. I also give FRANKLIN PIERCE staff/volunteers permission to take my child to the nearest medical treatment in case of emergency.

Signature of Participant	**Signature of Parent/Legal Guardian**
Date	**Date**