

Boys To Men Mentoring Network Of Greater Washington, Inc.

CONFIDENTIAL MEDICAL RECORD

The information we ask you to provide is for medical emergencies only. We will keep this information confidential. However, if your son becomes ill or injured during a Boys To Men event, we will share this information with emergency medical personnel.

General Information

Participant's Name _____

Parent's Name _____

Address _____

Daytime Phone _____ Evening Phone _____

Cell Phone _____ Fax Machine _____

Participant's Birth date ___/___/___ Participant's Soc. Sec. # (optional) ____-____-____

Emergency Contact _____ Relationship _____

Address _____ Daytime Phone _____

_____ Evening Phone _____

Cell Phone _____

Physician _____ Phone _____

Do you have health insurance? Yes ___ No ___

Insurance Company _____

Policy # _____ Phone _____

Address _____

In the event of a medical emergency, how would you like us to proceed?

Medical/Psychological History

Does your son have or had any medical/psychological condition *that you would want us to inform emergency medical personnel about?* ____ Y/N. If yes, please list below.

Condition	How long ago or at what age	Treatment Received	Other Relevant Information

Medications

Is your son taking any prescription medications? ____ Y/N If yes, please list below.

Medication	How much/how often	For	Current Side Effects

Will your son take prescription medications on the weekend? ____ Y/N If yes, please complete last page.

Medical or Other Allergies

Does your son have allergies? ____ Y/N If yes, please list below.

Allergy	Reaction

Signature Required

The information provided above is complete and accurate. I agree to notify Boys To Men Mentoring Network of Greater Washington should there be any changes in the information that I have provided here. I authorize Boys To Men Mentoring Network Northwest to release this information to medical personnel in an emergency.

Signature

Date

**Parents' Instructions to Boys To Men on
Administering Medications to Their Son**

Participant's Name _____

Medication	How much and when	Additional Information/Instructions

Please attach additional information as necessary.

Parent's Name _____

Parent's Signature _____

Date: _____