



Fusion Youth  
Annual Medical History and Agreement

Effective dates: September 2011- August 2012

**Emergency Contact Information:**

Please print in ink:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthday: \_\_\_\_\_

Male  Female      Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_

Policy # \_\_\_\_\_

Mother's name: \_\_\_\_\_ Phone H \_\_\_\_\_ W \_\_\_\_\_

Father's name: \_\_\_\_\_ Phone: H \_\_\_\_\_ W \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: H \_\_\_\_\_ W \_\_\_\_\_

Family Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_

**Medical History**

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof.

In connection with the ministry operations of Fusion Youth, I \_\_\_\_\_ (Guardian), as parent and/or legal guardian of \_\_\_\_\_ (Child), having the authority to execute this document, acknowledge and agree to the following:

1. I have advised Fusion youth that the above- listed Child has the following special medical needs:

Medical diagnosis of \_\_\_\_\_

Allergies to \_\_\_\_\_

Life- threatening reaction to this allergy is likely/probable\*

Moderate to severe (but not life-threatening) reaction to this allergy is likely/probable

Asthma

Other: \_\_\_\_\_



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2. As a result of this condition, multiple symptoms may appear, including:

Wheezing, panting, or other difficulty breathing

Seizures

Swelling (including restriction of airway)

Discoloration of Skin

Other: \_\_\_\_\_

3. In connection with this condition, I have provided the following medications and/or medical equipment:

\_\_\_\_\_

4. In the event that symptoms appear, I request the following course of action (check all that apply):

Locate one of the Child's guardians and advise him or her of the situation.

Contact emergency medical assistance by calling 911\*

Treat the symptoms in the following way (describe in detail, using page 3 of this form if necessary):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Date of last tetanus shot: \_\_\_\_\_

6. Please list and explain any major illnesses or surgeries your child experienced during the last year:

\_\_\_\_\_

\_\_\_\_\_

7. Do we have permission to administer the following over the counter medications to your child:  
(Parents please use your initials for checking off this medication)

Tylenol (acetaminophen) Yes \_\_\_\_\_ No \_\_\_\_\_ Advil (ibuprofen) Yes \_\_\_\_\_ No \_\_\_\_\_

8. I have included on this form a complete statement of medications, procedures, and or other interventions that are required in the event of an emergency: and I will provide all medications, inhalers, injectors, or other necessary items whenever the Child is participating in Fusion activities.



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9. I acknowledge and agree that, while Fusion will attempt to take appropriate action if such situations occur, Fusion is not a medical facility and cannot be held liable for any resulting injury.

For the Child to attend Fusion activities, the Guardian acknowledges and accepts the risks of injury associated with the Child's pre- existing condition while participating in Fusion activities. The Guardian also acknowledges and accepts the risks of injury or harm associated with intervention and/or treatment performed by Fusion workers.

ACCORDINGLY, THE GUARDIAN AGREES ON BEHALF OF BOTH THE GUARDIAN AND THE CHILD TO INDEMNIFY, DEFEND AND HOLD HARMLESS FUSION, AND ITS AGENTS, EMPLOYEES, VOLUNTEERS, AND OTHER REPRESENTATIVES FOR INJURY ARISING DIRECTLY OR INDIRECTLY OF THE DESCRIBED MEDICAL NEEDS OF THE CHILD.

Provide any additional comments, clarification or direction below:

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I agree that the above information is complete and accurate to the best of my knowledge, and I agree to the various terms of this Medical Conditions form.

Signature of parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Fusion Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**Please attach a copy of your insurance card listed on this form.  
If your insurance changes at any time during the year please submit a new copy of your card to Kristen Weller.**