

ISCC SKATER HEALTH EXAM/RECORD
SUMMER SKATING PROGRAM PARTICIPANT/APPLICANT
 Physical Exams Are Valid for 3 Years From Date of Last Examination

BASIC INFORMATION:

Name _____ Date of Birth _____ Home Phone _____
 Parent/Guardian _____ Address _____
 Work Phone _____ Medical Insurance _____ Policy No. _____
 Emergency Contact _____ Telephone _____
 Date of Arrival _____ Date of Departure _____

MEDICAL HISTORY (TO BE COMPLETED BY APPLICANT):

FAMILY HISTORY	Yes	No	Relationship	PERSONAL HISTORY	Yes	No	PERSONAL HISTORY (cont.)	Yes	No
CANCER				RHEUMATIC FEVER			ULCERS		
HIGH BLOOD PRESSURE				ANGINA PECTORIS			GALLBLADDER DISEASE		
TUBERCULOSIS				HEART ATTACK			JAUNDICE		
DIABETES				OTHER HEART DISEASE			BLOOD CLOTTING PROBLEMS		
EPILEPSY				HIGH BLOOD PRESSURE			COLITIS		
MIGRAINE				ANEMIA			DIABETES		
ASTHMA				KIDNEY DISEASE			ARTHRITIS		
HAY FEVER				GOUT			MIGRAINE		
CONGENITAL HEART				HAY FEVER			HEADACHE		
BLEEDING TENDENCY				ASTHMA			STROKE		
HEART ATTACK				BLOOD TRANSFUSION			PHLEBITIS		
STOMACH ULCERS				ALLERGIES (NON-DRUG)			"KELOID" SCARS		
KIDNEY DISEASE				FREQUENT RESPIRATORY INFECT.			EMPHYSEMA		
GOITER				NERVOUS BREAKDOWN			OTHER:		
COLITIS				DEPRESSION			PAST REACTION TO ANESTHETICS?		
NERVOUS BREAKDOWN				THYROID DISEASE			PAST HOSPITALIZATIONS?		

Please list any other medical condition that you have been treated for in the past; explain any injuries, hospitalizations or operations:

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Examination _____ May participate in all activities May participate with the following restrictions:

Medical information pertinent to routine care and emergencies:

Allergies YES NO Explain: _____

Special Diet YES NO Explain: _____

Additional Comments: _____

Immunizations	Yes	No	Immunizations	Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Signature of Physician, APRN or PA

Date Form Signed

Print Name of Care Provider

Medical Care Provider's Address

City/Town State Zip Code

Telephone Number

EMERGENCY MEDICAL INFORMATION & TREATMENT RELEASE

I, _____, hereby authorize the acting representative of the International Skating Center of Connecticut, L.L.C., or any physician and/or any member of the medical staff of any hospital or emergency treatment center to render medical treatment, which in his/her judgement may deemed necessary in the care of _____
I do hereby release, indemnify, and agree to hold harmless the agent and the International Skating Center of Connecticut, L.L.C. from all costs and/or liability arising from medical treatment or transportation.

Signature _____ Date _____
(Parent/Guardian if under 18 years of age)

***** THIS FORM AND YOUR SIGNATURE MUST BE NOTORIZED *****

Witness my hand and seal to the above signature this the ____ day of _____, 2003,
NOTARY PUBLIC _____ My commission expires: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY ISCC PERSONNEL

If ISCC is to administer medications, the Connecticut State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse, first aider, the director, alternate director or other personnel to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the skater, name of the drug, strength, dosage, frequency, physician's or dentist's name and date of the original prescription. Over-the-counter medication must be in the original container and labeled with the skater's name.

PHYSICIAN OR DENTIST'S ORDER: _____ Date: ____/____/____

Name of Skater: _____ Date of Birth: _____

Street Address: _____ City/Town Address: _____ State: _____

Condition for which medication is being administered: _____

DRUG: Name of Drug, Dose and Method of Administration: _____

Times of Administration: _____ Medication shall be administered from ____/____/____ to ____/____/____

Relevant side effects to be observed, if any _____

If there are side effects, plan for management _____

Is this a controlled drug? _____

Allergies to food or drugs? If YES, list _____

Physician's / Dentist's Name _____ Phone # () _____
(Please type or print)

Street Address _____ City/Town _____ State _____

Physician or Dentist's Signature _____

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION

To nurse, first aider, director, alternate director, or other ISCC personnel:

I hereby request that the above medication, ordered by the physician/dentist for _____, be Administered by the nurse, first aider, director, alternate director, or other ISCC personnel. I understand that I must supply ISCC With the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. Over-the-Counter medication shall be in the original container labeled with the skater's name. I understand that this medication will be Destroyed if it is not picked up within one (1) week following termination of the order.

Name of Parent/Guardian _____ Signature _____ Date _____

Relationship to skater _____ Street Address _____ City/Town _____ State _____