

OHIO SEA GRANT AND STONE LABORATORY

Medical History Form 2017

Please sign and upload your completed form with your application.

1. Do you have any food, medication, or other allergies? Yes No

If yes, please describe _____

2. Are you currently taking medication? Yes No If so, please list what type and dosage. _____

3. Do you have special requirements or limitations that prohibit you from participating in field excursions? Yes No

If yes, please describe _____

4. I have medical coverage through
(please write Insurance Company Name) _____

I give my consent for any medical treatment that I or my child, whose name is printed below, might require while in the 2017 Stone Lab program. I authorize and request The Ohio State University Stone Laboratory personnel to refer me or my child to a duly licensed medical authority when indicated, including transfer to hospitals. I hereby grant authority to a qualified physician to render such medical treatment as the physician deems necessary under the circumstances.

5. In the event of an emergency, please contact

Primary contact	Phone
_____	_____
Secondary contact	Phone
_____	_____

6. My or my child's regular physician is

Dr.	Phone
_____	_____
Address	

7. Name and signature

Participant's Full Name (please print)		Parent/Guardian Name (please print)	
_____		_____	
Participant Legal Signature	Date	Parent/Guardian Legal Signature (if participant is under 18 years old)	Date
X		X	

