DISTINGUISHED YOUNG WOMEN
SCHOLARSHIP | LEADERSHIP | TALENT

HEALTH FORM

Name: _____ Date of Birth: _____
DYW Program name: _____ State:_____Year: _____
Street address: _____
City: _____ State:_____Zip: _____

Physician: _____ Phone: _____ Date of last physical exam: _____
Dates and reasons for past hospitalizations: _____
Medical Insurance Company and Plan: _____
Member's name, policy number & group number: _____

Explain any allergies to medicines (or write none): _____
_____
Explain any other allergies (e.g. pets/hay fever/foods): _____
_____
If you take allergy medication, please list types and dosage here: _____
_____
List all other current medications: _____
_____
If you are you on a special diet, including vegetarian, pescatarian, or vegan, please explain what you do not eat: _____
_____
Religious preference in case of emergency (be specific):_____

Please check the box for each over-the-counter medication that may be administered:

- ❑ Tylenol
- ❑ Aleve
- ❑ Cough Syrup
- ❑ Decongestant
- ❑ Antacid
- ❑ Pepto Bismol

If there are any medical conditions that could limit your full participation in this program in any way, including practicing and performing the fitness routine, please explain here: _____
_____
_____

To the best of my knowledge, all of the above information is correct. I believe there is no physical condition or other condition that will limit the full participation by the participant named above in the Distinguished Young Women Program, except as noted above. **Should a medical problem arise, I give consent to such medical treatment as deemed necessary by a licensed physician or nurse and agree to be financially responsible for the cost of any such assistance or treatment.**

Parent/guardian's signature _____ Date _____
Print Name: _____
Please list two emergency contacts:
1. _____ Relationship: _____
Home phone: _____ Cell phone: _____
2. _____ Relationship: _____
Home phone: _____ Cell phone: _____