



BOYS TO MEN CONFIDENTIAL MEDICAL RECORD

In order to acquaint our staff with your son's medical needs, we ask that you complete this Confidential Medical Record. If your son becomes ill or is injured on the weekend we may share this information with medical personnel. Otherwise, all information will be kept strictly confidential. Please complete every item in every section. Mark N/A if any section is not applicable. If you are mailing this form to us, please keep a photocopy.

General Information

Boy's Name _____ Birth date ____/____/____

Address _____

Daytime Phone _____ Evening Phone _____

Emergency Contact _____ Relationship _____

Address _____ Daytime Phone _____
_____ Evening Phone _____

Physician _____ Phone _____

Insurance Co.: _____ Phone _____

Policy Number: _____ Expiration Date: _____

1. Does your child have any medical or physical conditions that would affect his participation in the Boys To Men Adventure Weekend?

2. Does your child need any medication during the weekend? If so please give all medications to the staff person on Friday when you drop off your child.

3. Does your child have any emotional or psychological concerns that need to be addressed?

4. In case of medical emergency please list specific instruction

5. Food Allergies

Medical History

Does your son have, or has he ever had, any of the following conditions or symptoms?
Please specify **Yes** or **No** for each condition.

	Yes	No		Yes	No		Yes	No
1.Vision Impairment	<input type="radio"/>	<input type="radio"/>	19.Difficulty Urinating	<input type="radio"/>	<input type="radio"/>	38.Learning Disability	<input type="radio"/>	<input type="radio"/>
2.Hearing Impairment	<input type="radio"/>	<input type="radio"/>	20.Kidney Problems	<input type="radio"/>	<input type="radio"/>	39.Frequent Dizziness	<input type="radio"/>	<input type="radio"/>
3.High Blood Pressure	<input type="radio"/>	<input type="radio"/>	21.Obesity	<input type="radio"/>	<input type="radio"/>	40.Frequent Fainting	<input type="radio"/>	<input type="radio"/>
4.Heart Disease	<input type="radio"/>	<input type="radio"/>	22.Arthritis	<input type="radio"/>	<input type="radio"/>	41.Diabetes	<input type="radio"/>	<input type="radio"/>
5.Heart Murmur	<input type="radio"/>	<input type="radio"/>	23.Broken Bones	<input type="radio"/>	<input type="radio"/>	42.Hypoglycemia	<input type="radio"/>	<input type="radio"/>
6.Elevated cholesterol	<input type="radio"/>	<input type="radio"/>	24.Neck or Back Problems	<input type="radio"/>	<input type="radio"/>	43.Eating Disorders	<input type="radio"/>	<input type="radio"/>
7.Irregular Heartbeat	<input type="radio"/>	<input type="radio"/>	25.Joint Problems	<input type="radio"/>	<input type="radio"/>	44.Thyroid Problems	<input type="radio"/>	<input type="radio"/>
8.Family history of heart attack	<input type="radio"/>	<input type="radio"/>	26.Muscle Cramps	<input type="radio"/>	<input type="radio"/>	45.Endocrine or Gland Problems	<input type="radio"/>	<input type="radio"/>
9.Circulation Problems	<input type="radio"/>	<input type="radio"/>	27.Tuberculosis	<input type="radio"/>	<input type="radio"/>	46.Unexplained weight loss	<input type="radio"/>	<input type="radio"/>
10.Chest Pain/Pressure	<input type="radio"/>	<input type="radio"/>	28.Exposure to TB	<input type="radio"/>	<input type="radio"/>	47.Bleeding Disorder	<input type="radio"/>	<input type="radio"/>
11.Heart Palpitations	<input type="radio"/>	<input type="radio"/>	29.Recurrent lung infections	<input type="radio"/>	<input type="radio"/>	48.Blood disorder or anemia	<input type="radio"/>	<input type="radio"/>
12.Shortness of Breath	<input type="radio"/>	<input type="radio"/>	30.Active Hepatitis	<input type="radio"/>	<input type="radio"/>	49.Sickle cell disease or trait	<input type="radio"/>	<input type="radio"/>
13.Chronic cough	<input type="radio"/>	<input type="radio"/>	31.History of Hepatitis B or C	<input type="radio"/>	<input type="radio"/>	50.Cancer	<input type="radio"/>	<input type="radio"/>
14.Asthma	<input type="radio"/>	<input type="radio"/>	32.HIV Positive or AIDS	<input type="radio"/>	<input type="radio"/>	51.Skin Problems	<input type="radio"/>	<input type="radio"/>
15.Ulcers	<input type="radio"/>	<input type="radio"/>	33.Unexplained Sweating	<input type="radio"/>	<input type="radio"/>	52.Special Dietary Needs	<input type="radio"/>	<input type="radio"/>
16.Intestinal Problems	<input type="radio"/>	<input type="radio"/>	34.Seizure Disorder	<input type="radio"/>	<input type="radio"/>	53.Medical Equipment/Devices	<input type="radio"/>	<input type="radio"/>
17.Heartburn	<input type="radio"/>	<input type="radio"/>	35.Seizure within past year	<input type="radio"/>	<input type="radio"/>	54. Special Physical Requirements	<input type="radio"/>	<input type="radio"/>
18.Bladder Infections	<input type="radio"/>	<input type="radio"/>	36.Headaches	<input type="radio"/>	<input type="radio"/>	55.Psychiatric/Emotional Problems	<input type="radio"/>	<input type="radio"/>
			37.Significant Head Injury	<input type="radio"/>	<input type="radio"/>	56.Other	<input type="radio"/>	<input type="radio"/>

If you have answered "yes" to any of the above items, please explain in the Detailed Responses section at the bottom of this form.

Height _____ Weight _____ Age _____ Has he ever been hospitalized? Yes No

Psychosocial History

Has he been in counseling with a psychiatrist, psychologist, or other counselor within the past two years? Yes No

Is he currently in counseling/treatment? Yes No If yes, please describe briefly on previous page.

Reason for counseling (check all appropriate responses): Academic Family Issues

Depression Substance Abuse Suicide Other

Primary counselor _____

Phone(s) _____

Address _____

Has he ever used alcohol, tobacco or non prescription drugs that you are aware of? Yes No

If yes, please describe:

When was the last time he used alcohol, tobacco or non-prescription drugs?

Alcohol _____

Tobacco _____

Non-prescription Drug _____

Do you suspect that he may have a substance abuse problem? Yes No

If yes, please explain:

Signature Required

The information provided above is a complete and accurate statement of the physical and psychological factors that may affect my son's participation in The Boys To Men Rite of Passage Weekend. I realize that failure to disclose such information could result in serious harm to himself and to fellow participants

I agree to notify Boys To Men Mentoring Network should there be any changes in his health status. I authorize Boys To Men Mentoring Network to release this information to medical personnel in an emergency. I also authorize Boys To Men Mentoring Network to contact his physician or therapist to clarify any questions about his health. I understand that Boys To Men Mentoring Network reserves the right to refuse participation to any boy for medical reasons.

Parent or Guardian signature: _____

Print Name: _____ Date: _____