St. Louis Alumnae Chapter
Delta Sigma Theta Sorority, Incorporated
Delta G.E.M.S. Health Information Form

Youth's Name: _____ Youth's Date of Birth: _____/_____/_____
Last, First Middle

Youth's Address: _____ City: _____ State: _____ Zip: _____

Name of Mother or Legal Guardian: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Name of Father or Legal Guardian: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Emergency Contact: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Does your child have any significant food/medication. environmental allergies that may require emergency medical care during activities with the Delta G.E.M.S. Program? ☐Yes ☐No (If so, please list below)

_____

_____

Describe any other important health-related information (health history, conditions, illnesses, restrictions, etc.) about your child that may affect your child's participation in the Delta G.E.M.S. Program? (if none, write N/A)

_____

_____

Does your child take any prescribed medications? ☐Yes ☐No

If so, please list all prescription, over-the-counter, and herbal medications your child takes regularly:

Prescription Name	Frequency Taken	Prescription Name	Frequency Taken

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

_____ Date:_____/_____/_____

Signature of person completing this form

St. Louis Alumnae Chapter
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Delta G.E.M.S. Emergency Medical Treatment Authorization Form

Youth's Name: _____ Youth's Date of Birth: _____/_____/_____
Last, First Middle

Youth's Address: _____ City: _____ State: _____ Zip: _____

Name of Mother or Legal Guardian: _____ Relationship to Youth: _____

Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Mother/Legal Guardian's Address: _____

City: _____ State: _____ Zip: _____ Email Address: _____

Name of Father or Legal Guardian: _____ Relationship to Youth: _____

Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Father/Legal Guardian's Address: _____

City: _____ State: _____ Zip: _____ Email Address: _____

If for any reason I/we cannot be reached, please contact eh following person(s) whom I/we hereby authorize to seek emergency medical or surgical care for my/our child:

Designee's Name: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Relationship to Youth: _____

Designee's Name: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Relationship to Youth: _____

In the event that the G.E.M.S. Program is unable to reach any of the individuals named above promptly by phone, I/we authorize the G.E.M.S. Program Committee to seek and secure any emergency medical or surgical care for my/our child. I/We will be responsible for any and all expenses incurred and authorize the medical facility at which treatment is rendered to release all necessary information to my/our insurance company. Initial Here: _____ Initial Here: _____

Physician and Insurance Information

Name of Youth's Physician: _____ Phone: _____-_____-_____

Health Insurance Company: _____ Phone: _____-_____-_____

Policy Number: _____ Group Number: _____

Name of Policy Holder: _____ Name of Policy Holder's Employer: _____

Parent/Guardian Signature:
_____

Printed Name: _____

Date: _____

Parent/Guardian Signature:
_____

Printed Name: _____

Date: _____