Aerospace Center for Excellence
A Florida Corporation Not for Profit
Medical History

Name of Child: First, Last Name **Date:** Today's Date.

Diagnosed with: ☐Asthma
☐ Lunch Disease
☐ Diabetes
☐ Takes Insulin

Chronic Infection of: ☐Nose
☐Throat
☐Ears
☐Sinus

Subject to: ☐Disability
☐ Fainting
☐Frequent Headaches
☐Hyperactivity
☐Bedwetting
☐Sleepwalking
☐Motion Sickness
☐Restlessness
☐Nose Bleeds

Allergies (If yes, to what?):
Medications ☐Yes ☐No
Foods ☐Yes ☐No
Insects ☐Yes ☐No
Pollen ☐Yes ☐No
Aspirin ☐Yes ☐No
Aspirin Substitute ☐Yes ☐No
(NOTE: Child should be aware of food allergies and limit his/her consumption as needed)

List List
Tetanus inoculation date: Date.
Has girl menstruated? ☐Yes ☐No
(Painful? Irregular?) ☐Yes ☐No

Any recent exposure to contagious disease? ☐Yes ☐No When? When?
To what? To what?

Any recent operations? ☐Yes ☐No If yes, list: List

List Present Medications: Medication Taken For
Medication Taken For
Medication Taken For

Should your child be restricted from any activity? ☐Yes ☐No If yes, list: list

Additional Information: Additional Information

Initial Medication Administration: ACE reserves the right to determine on a case-by-case basis if it will administer prescription medications. A consent form for administration of medication must be completed by parent/legal guardian and given to the Education Director for approval. ACE has the right to refuse to accept medication and/or refuse to administer medication. If accepted all medication must be in original packaging and labeled indicating dosage prescribed by physician, in no event shall ACE administer over-the-counter medications.

Initial If child has suffered a serious accident or illness within the past twelve months or is subject to a more serious health condition or if there is any question about activity restriction, at the discretion of the Education Director further information or specific permission to participate in activities may be required for which the doctor may be contacted and a written physician consent obtained. The staff and volunteers may not be qualified to care for some special needs therefore further services evaluation may be necessary for care to be provided. Reasonable accommodations that do not alter ACE's program may be made.

Initial In the event my child suffers any illness or accident requiring emergency treatment while involved in any ACE activity, I hereby give permission for any necessary hospitalization, medication, or surgery on recommendation of medical personnel, in which case all such expenses shall be paid by me. In the event of sickness or accident, I waive all claims against volunteers, staff, ACE Board Members, or operators of ACE or its agents that may arise from participation in the activities of the Aerospace Center for Excellence, Inc. (ACE).

Parent/Legal Guardian Signature **Today's Date**