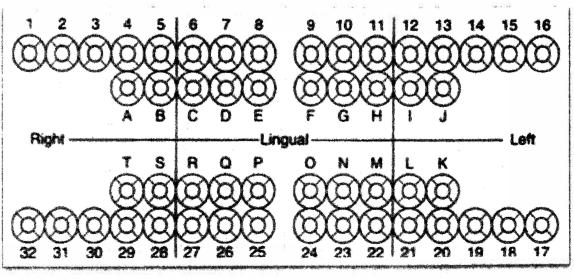
· 1	nımııpuu	Health Medica	al History Form	- Youth	
Patient's Name	FIRST	MIDDLE INITIAL	Nickname	Date of Birth	
Parent's/Guardian's Name	FIRST	MIDDLE INITIAL		Defication Crede Level	
Tarent or Oddidian's Hame			Trelationship to Fatient	Patient's Grade Level	
Phone Home		Work		Sex M F	
1. Active Tuberculosis,	Persistent cou	nad any of the following disease gh greater than a three-week du ove, please stop and return this			. Y N
Has the child had any h	istory of, or conditi	ons related to, any of the follo	wing:	3 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	3 (4 {= 0 ⁺ 5
Cerebral PalsyY N F Growth ProblemsY N K HearingY N C Latex allergyY N F	aintingYN KidneyYN Chicken PoxYN Rheumatic Fever.YN	ImmunizationsY N Mum Pregnancy (teens)Y N Tube HepatitisY N Arthr Bleeding disorders.Y N Diab	AIDSY N Mononucleosis	Y N AsthmaY N Y N Sickle cellY N Y N MeaslesY N Y N Sexually Transmitted In	fectionY N
Please list the name and pho	ne number of the child's	s medical provider:			
Name of Provider			Phone		
		·	vitamin supplements at this time?		YN
			rugs? If yes, please explain:		
Is the child allergic to	anything else, such a	as certain foods? If yes, please	explain:		YN
has the child ever had	a a serious iliness? ir	yes, when:P	lease describe:		_ T IN
			se describe:		ΥN
Does the child have a history of any other illnesses? If yes, please list:					YN
Is the child physically,	mentally, or emotion	nally impaired?			. Y N
Does the child experie	ence excessive bleed	ling when cut?			YN
Has the child had any	problem with dental	treatment in the past?			ΥN
The answers I have given a physicals[], X optical [], X to provide comfort during d	are true to the best of -rays [], fluoride [] lental care. It is safe	f my knowledge. I am indicating , fillings [], and <u>simple extract</u> but has certain risks. Common r	consent for routine procedures such tions of primary teeth[]. Dental an isks are bruising, swelling, or pain at rely occur. I consent to the use of an	as; [] immunizations [],sp esthetic (topical or local) is c the site of the injection. A te	orts ommonly use
Parent's/Guardian's Signat	ure		- M	Date	
Provider's Signature		#		Date	
☐ Yes, I approve Nat	ional Guard medi	cal services May 12-21, 202	5	_Date:	
1	2 3 4	5 6 7 8	9 10 11 12 13 1	4 15 16	



Media Release Form Nimiipuu Health



I,, hereby grant permission to Nimiipuu Health and/or the United States
National Guard, the rights of my image, in video or still, and the likeness and sound of my voice as recorded on audio or video. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive the right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.
Photographic, audio or video recordings may be used for ANY USE which may include but is not limited to: • Presentations • Courses
Online/Internet VideosMedia
Social Media
News (Press)
By signing this release, I understand this permission signifies that photographic or video recordings of me may be displayed via the Internet or in a public educational setting. I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.
There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed for use in an any setting.
By signing this release, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material.
Full Name-Printed (Parent/Guardian if under 18):
Minor Full Name-Printed:
Phone Number and/or Email:
Email Address:

Signature (Parent/Guardian if under 18) ______ Date_____