

Health and Medical Record/Release

IDENTIFICATION

Name _____ Birth Date _____

Address _____ Phone _____

City _____ State _____ Zip _____

Male Female Religion _____

HEALTH HISTORY

Have you had any of the following conditions? Mark "past" or "now" or leave blank if never had.

_____ Asthma	_____ Bedwetting	_____ Epilepsy
_____ Hay Fever	_____ Kidney Disease	_____ Rheumatic Fever
_____ Sinus Trouble	_____ Constipation	_____ Heart Trouble
_____ Ear Ache/Infection	_____ Frequent Diarrhea	_____ Glasses
_____ Ear Tubes	_____ Severe Stomach Ache	_____ Contact Lenses
_____ Fainting Spells	_____ Diabetes	_____ Menstrual Problems
_____ Tuberculosis	_____ Sleep Walking	

ALLERGIES OR ALLERGIC REACTIONS (Check if yes and tell what the symptoms are)

- Penicillin _____
- Other Medications (List): _____
- Bee Sting _____
- Food _____
- Poison Oak, Poison Ivy _____
- Other: List _____
- _____
- _____

PLEASE LIST ALL SERIOUS ILLNESSES OR OPERATIONS IN THE PAST FIVE YEARS

Operation or Illness	Date	Hospitalized? (yes/no)
_____	_____	_____
_____	_____	_____

PLEASE LIST ALL MEDICATIONS CURRENTLY BEING TAKEN

Medication	Number of Times a Day	Reason for Taking
_____	_____	_____
_____	_____	_____

IMMUNIZATION HISTORY (or attach copy of current immunization record)

Required immunizations must be determined locally. This is a record of dates of being immunized and most recent booster doses.

DTP Series _____ Booster _____

Polio (IPV) _____ Booster _____

MMR (measles/mumps/Rubella) _____

Tetanus Booster _____

Chicken Pox _____

DIET Regular Vegetarian Diabetic Low Salt Low Fat/Cholesterol

Other - Special Instructions _____

PHYSICAL ACTIVITY

Any restriction of activity for medical reasons? Explain: _____

Any other type of health concerns which might be pertinent? _____

Name: _____

INFORM IN CASE OF ACCIDENT OR ILLNESS

Father/Guardian _____ Phone (H) _____

Home Address _____ Phone (Cell): _____

_____ Phone (W) _____

Mother/Guardian _____ Phone (H) _____

Home Address _____ Phone (Cell): _____

_____ Phone (W) _____

If not available, in emergency notify:

Name _____ **OR** Name _____

Address _____ Address _____

Phone (H) _____ Phone (H) _____

Phone (Cell) _____ Phone (Cell) _____

DOCTOR TO CONSULT IN CASE OF EMERGENCY

Name _____ Phone () _____

Address _____ City _____

_____ State _____ Zip _____

DO YOU HAVE Medical Insurance Yes No Number _____ Type Coverage _____

Company Name _____

Information above is correct to the best of my knowledge.

Date _____ Signed _____

Parent's Authorization—required for those less than 18 years of age.

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injection or surgery for my child.

Parent/Guardian's Signature _____

Date _____

Witness Signature: _____