Health and Medical Record/Release

IDENTIFICATION

Name ______________________ Age __________ 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	_______ Fainting Spells	_______ Frequent Diarrhea	_______ Rheumatic Fever
_______ Hay Fever	_______ Tuberculosis	_______ Severe Stomach Ache	_______ Heart Trouble
_______ Sinus Trouble	_______ Bedwetting	_______ Diabetes	_______ Glasses
_______ Ear Ache/Infection	_______ Kidney Disease	_______ Sleeping Walking	_______ Contact Lenses
_______ Ear Tubes	_______ Constipation	_______ Epilepsy	_______ Menstrual Cramps

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

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

DTP Series	__________ Booster _______	Tetanus Booster	______________
Polio OPV (Sabin)	__________ Booster _______	Tuberculin Test	______________
Measles Vaccine (live)	______________	Mumps Vaccine (live)	______________
German Measles (Rubella)	______________	Chicken Pox	______________

DIET ❑ Regular ❑ Diabetic ❑ Low Salt ❑ Low Fat/Cholesterol

❑ Other - Special Instructions ______________________

PHYSICAL ACTIVITY Name: ____________________

Any restriction of activity for medical reasons? Explain: ____________________

____

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

____

INFORM IN CASE OF ACCIDENT OR ILLNESS

Father/Guardian____________________ Phone (H) ____________
Home Address ____________________ Cell ____________
____
Work Address ____________________ Phone (W) ____________
____

Mother/Guardian______ ____________________ Phone (H) ____________
Home Address ____________________ Cell ____________
____
Work Address ____________________ Phone (W) ____________
____

If not available, in emergency notify:

Name ____________	**OR**	Name ____________
Address ____________		Address ____________
____________		____________
Phone (H) ________ (W) ________		Phone (H) ________ (W) ________

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 or Guardian

Parent's Authorization*—required for those under 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 ____________________

Subscribed and sworn to before me this ______ day of ____________

____
Notoary Public

My commission expires ____________