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

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 _____________