

# Georgia Cumberland Conference Health History Form - Staff

Club Name: <b>Collegedale Pathfinders</b>		Director Name:	
Legal Name:		Preferred Name:	
Age	Birthdate _____ / _____ / _____ Month/ Day/ Year	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Mailing Address			
City		State	Zip
<b>Primary contact in case of illness or injury:</b>			
Name:		Relation to Staff:	
Primary Phone: ( ) ( ) ( )		Alternate Phone: ( ) ( ) ( )	
<b>2nd emergency contact (optional):</b>			
Name:		Relation to Staff:	
Primary Phone: ( ) ( ) ( )		Alternate Phone: ( ) ( ) ( )	
<b>Additional contact in event contacts(s) can not be reached (optional):</b>			
Name:		Relation to Staff:	
Primary Phone: ( ) ( ) ( )		Alternate Phone: ( ) ( ) ( )	
<b>Health Care Providers</b>			
Physician	City	Office Phone: ( ) ( ) ( )	
Dentist	City	Office Phone: ( ) ( ) ( )	
Orthodontist	City	Office Phone: ( ) ( ) ( )	
<b>Health Insurance Information</b>			
This staff is covered by health insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Holder
Insurance Company	Phone: ( ) ( ) ( )	Holder's Birthdate: _____ / _____ / _____ Month/ Day/ Year	
Employer	Policy Number:	Group Number:	
<b>Immunizations</b>			
Are all immunizations, up-to-date? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>Tetanus Status:</b> Month _____ Year _____ (The month and year of the most recent Tetanus shot is <b>required</b> )			
If doctor advises, may Tetanus Immunization be administered? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> _____ *			
<b>General Health History:</b> Check "Yes" or "No" if staff has or had a history of the following:			
1. Asthma/wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Back or joint problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Stomach Upsets	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Sprain, Dislocation etc	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Sleep problems or Sleepwalking	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Sinusitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Recurrent/chronic illnesses.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Ear Infections/Ear Tubes (circle)	<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Communicable (Infectious) Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Frequent Sore Throats	<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Eye Glasses/Contacts (circle)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (not listed)			
<b>List any hospitalizations, Surgeries or Broken Bones:</b>			
<b>Year</b>	<b>Hospitalization/Surgery/Broken Bones</b>	<b>Explanation</b>	

# Georgia Cumberland Conference Health History Form (continued)

Club Name: <b>Collegedale Pathfinders</b>	Director Name: _____
Legal Name: _____	Birthdate: ____/____/____ Month/ Day/ Year

**Allergies:**

No known allergies

Allergic to:       Food(s)     Medicine(s)     Environment (insect, pollen, etc.)     Other

List all Allergies:	Reaction

**Medications/Vitamins/Natural Remedies Staff Needs (if applicable to emergency treatment):**

This person will **not** take any daily medications while attending events.

This person will need to take the following medications while attending events:

**List medications, vitamins, etc. to be taken:** (Any psychotropic drugs must be at the therapeutic level – 3 months minimum use.)

Medication Name	Dose	Frequency	Reason	What happens if dose is missed?
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Dinner <input type="checkbox"/> Other <input type="checkbox"/> Lunch <input type="checkbox"/> Bedtime    _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Dinner <input type="checkbox"/> Other <input type="checkbox"/> Lunch <input type="checkbox"/> Bedtime    _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Dinner <input type="checkbox"/> Other <input type="checkbox"/> Lunch <input type="checkbox"/> Bedtime    _____		

If there are any restrictions on Activities or Diet please note here:

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<b>*Staff Signature</b>	<b>Date</b>
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Please Note: Health insurance remains the family's responsibility to provide.