

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 _____

Notary Public

My commission expires _____