Georgia Cumberland Conference Health History Form - Staff

Club Name: Collegedale Pathfinders		Director Name: Dianna Knapp	
Legal Name:			Preferred Name:
Age	Birthdate_____/_____/_____ Month/ Day/ Year		Gender: ☐ Female ☐ Male
Mailing Address			
City	State		Zip

Primary contact in case of illness or injury:

Name:	Relation to Staff:
Primary Phone: ( )	Alternate Phone: ( )

2nd emergency contact (optional):

Name:	Relation to Staff:
Primary Phone: ( )	Alternate Phone: ( )

Additional contact in event contacts(s) can not be reached (optional):

Name:	Relation to Staff:
Primary Phone: ( )	Alternate Phone: ( )

Health Care Providers

Physician	City	Office Phone: ( )
Dentist	City	Office Phone: ( )
Orthodonist	City	Office Phone: ( )

Health Insurance Information

This staff is covered by health insurance? ☐ Yes ☐ No		Policy Holder
Insurance Company	Phone: ( )	Holder's Birthdate: _____/_____/_____ Month/ Day/ Year
Employer	Policy Number:	Group Number:

Immunizations

Are all immunizations, up-to-date? Yes ☐ No ☐

Tetanus Status: Month_____ Year_____ (The month and year of the most recent Tetanus shot is **required**)

If doctor advises, may Tetanus Immunization be administered? ☐ Yes ☐ No

☐

_____

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General Health History: Check "Yes" or "No" if staff has or had a history of the following:

1. Asthma/wheezing	☐ Yes	☐ No	10. Seizure Disorder	☐ Yes	☐ No
2. Diabetes	☐ Yes	☐ No	11. Fainting or dizziness	☐ Yes	☐ No
3. Back or joint problems	☐ Yes	☐ No	12. Heart Condition	☐ Yes	☐ No
4. Headaches	☐ Yes	☐ No	13. Stomach Upsets	☐ Yes	☐ No
5 Diarrhea	☐ Yes	☐ No	14. Sprain, Dislocation etc	☐ Yes	☐ No
6. Constipation	☐ Yes	☐ No	15. Sleep problems or Sleepwalking	☐ Yes	☐ No
7. Sinusitis	☐ Yes	☐ No	16. Recurrent/chronic illnesses.	☐ Yes	☐ No
8. Ear Infections/Ear Tubes (circle)	☐ Yes	☐ No	17. Communicable (Infectious) Disease	☐ Yes	☐ No
9. Frequent Sore Throats	☐ Yes	☐ No	18. Eye Glasses/Contacts (circle)	☐ Yes	☐ No

Other (not listed)_____

List any hospitalizations, Surgeries or Broken Bones:

Year	Hospitalization/Surgery/Broken Bones	Explanation

Georgia Cumberland Conference Health History Form (continued)

Club Name: Collegedale Pathfinders	Director Name: Dianna Knapp
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?
		☐ Breakfast ☐ Dinner ☐ Other ☐ Lunch ☐ Bedtime _____		
		☐ Breakfast ☐ Dinner ☐ Other ☐ Lunch ☐ Bedtime _____		
		☐ Breakfast ☐ Dinner ☐ Other ☐ Lunch ☐ Bedtime _____		

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

_____

_____

_____

_____

***Staff Signature** **Date**

Please Note: Health insurance remains the family's responsibility to provide.