

MEDICAL FORM AND PERSONAL HEALTH HISTORY

Name _____ Date of Birth _____ Age _____

Parent/Guardian _____ Phone(s) _____

Emergency Contact _____ Relationship _____ Phone _____

Physician _____ Phone _____

Insurance Carrier and Policy Number _____

HEALTH HISTORY (Check if applicable and date)

___ Asthma ___ Diabetes ___ Hay Fever ___ Sleepwalking ___

___ Heart Disease ___ Ear Infection ___ High Blood Pressure ___

___ Convulsions/Seizures ___ Fainting ___ Frequent Headaches ___

___ Glasses/Contacts ___ Hypertension ___ Nosebleeds ___

IN CASE OF EMERGENCY: I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the person(s) in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if adult participant).

Date _____ Signature of parent/guardian or adult _____

IMMUNIZATIONS (Give date of last inoculation)

D.T.P. _____ Diphtheria _____ Measles _____

Mumps _____ Rubella _____ Oral Polio _____

Tetanus _____ Pertussis _____ Whooping Cough _____

PLEASE LIST ANY KNOWN ALLERGIES AND/OR CURRENT MEDICATIONS
