

HEALTH FORM

Participant's Name: _____ Sex: M F Age: _____ Birthdate: ____/____/____
Parents'/Guardians' Names: _____ Home Phone: _____ Cell Phone: _____
Mailing Address: _____ Work Phone: _____
Family Physician: _____ Phone: _____
Family Health Insurance Co.: _____ Ins. #: _____

This individual was last examined by a physician: ____ Month ____ Year

Is this individual subject to or bothered frequently with any of the following:

	Yes	No		Yes	No		Yes	No		Yes	No
Menstrual Cramps	___	___	Sore Throat	___	___	Asthma/Hay Fever	___	___	Upset Stomach	___	___
Colds/Flu	___	___	Drug Sensitivity	___	___	Constipation	___	___	Athletes Foot	___	___
Ear Infection	___	___	Hernia	___	___	Fainting Spells	___	___	Epilepsy	___	___
Sinusitis	___	___	Heart Trouble	___	___	Headaches	___	___	Other	___	___
Tonsillitis	___	___	Rheumatic Fever	___	___						

Allergies: _____

Medication or Treatment: _____

What vaccinations & immunizations has this individual had? *(Specify years given, if known.)* _____

Has this person been exposed to communicable diseases within the past two weeks? Yes No

Does this person wear: Eye Glasses Yes No *(If yes, please mark glasses with youth's name.)*

Contact Lenses Yes No *(If yes, please mark case with youth's name.)*

Has this person been advised by your family physician at this time to:

Limit physical exercise Yes No Take a special medication Yes No

Use a special diet Yes No Explain other special instructions, if any _____

This health history is correct as far as I know, and my son/daughter/ward has my permission to engage in all prescribed activities, except as noted by me and the physician. In the event of a serious injury or illness, I will be notified. If I cannot be reached in an emergency, I hereby give my permission to the physician to hospitalize, secure proper treatment for and to order injections, anesthesia or surgery for my son/daughter/ward.

(Signature of Parent or Guardian)

(Date)

If parents are not available, in case of emergency notify:

Name: _____

Phone: _____