

HEALTH AND MEDICAL RECORD

IDENTIFICATION

Name _____ Age _____ Birth Date _____
Address _____ Home Phone _____
City _____ State _____ Female Male
Social Security Number _____ Religion _____

HEALTH HISTORY

Have you had any of the following conditions? Mark "past" or "now" or leave blank if never had.

Asthma _____	Bed wetting _____	Epilepsy _____
Hay Fever _____	Kidney Disease _____	Rheumatic Fever _____
Sinus Trouble _____	Constipation _____	Heart Trouble _____
Ear ache, Ear Infection _____	Frequent Diarrhea _____	Glasses _____
Ear Tubes _____	Severe Stomach Ache _____	Contact Lenses _____
Fainting Spells _____	Diabetes _____	For Women: _____
Tuberculosis _____	Sleep Walking _____	Menstrual Problems _____

ALLERGIES OR ALLERGIC REACTIONS (Check if yes, then tell what happened.)

- 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 MEDICATION CURRENTLY BEING TAKEN

Medication	Times per 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 _____
Polio OPV (Sabin) _____	Booster _____
Measles Vaccine (live) _____	
German Measles (Rubella) _____	
Tetanus Booster _____	
Tuberculin Test _____	
Mumps Vaccine (live) _____	
Chicken Pox _____	

DIET Regular Diabetes Low Salt Low Cholesterol Other _____
Special Instructions _____

PHYSICAL ACTIVITY

Any restriction of activity for medical reasons? Please explain _____

Any other type of health concerns which might be pertinent?

INFORM IN CASE OF ACCIDENT OR ILLNESS

Parent/Guardian/Spouse _____
Home Address _____ Home Phone _____

Work Address _____ Work Phone _____

If above named person is not available, please notify

Name _____
Address _____

Name _____
City _____
State _____ Zip _____

DO YOU HAVE

Medical Insurance? Yes No Number _____ Type Coverage _____

Name of Company _____

The information listed above is correct to the best of my knowledge.

Signed _____ Date _____
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 son or daughter. A photostatic copy of this shall be as valid as the original.

Signature _____
Parent or Guardian

Date _____

Subscribed and sworn to before me this _____ day of _____

Notary Public
My commission expires _____