

Health History Record					Adult <input type="checkbox"/>	Girl <input type="checkbox"/>
NAME OF MEMBER	DATE OF BIRTH	SEX	AGE	PARENT/GUARDIAN NAME(S)		
ADDRESS				PHONE: (AREA CODE) DAY		
CITY		STATE	ZIP	PHONE: (AREA CODE) EVENING		
IN EMERGENCY NOTIFY: NAME	RELATIONSHIP	PHONE: (AREA CODE) DAY	(AREA CODE) EVENING	FAMILY MEDICAL/HOSPITAL INSURANCE CARRIER		
IN EMERGENCY NOTIFY: NAME	RELATIONSHIP	PHONE: (AREA CODE) DAY	(AREA CODE) EVENING	POLICY OR GROUP NO.		
CHECK THOSE THAT APPLY TETANUS: <input type="radio"/> CURRENT - LAST BOOSTER? (YEAR) _____ ANY RESTRICTIONS CONCERNING PHYSICAL ACTIVITIES? <input type="radio"/> YES <input type="radio"/> NO PLEASE DESCRIBE ANY CONDITIONS: _____ _____ _____ _____		CHRONIC OR RECURRING ILLNESS: <input type="radio"/> HEART DEFECT/DISEASE _____ <input type="radio"/> SEIZURES _____ <input type="radio"/> BLEEDING/CLOTTING _____ <input type="radio"/> ASTHMA _____ <input type="radio"/> DIABETES _____ <input type="radio"/> OTHER (SPECIFY) _____ ALLERGIES: <input type="radio"/> FOOD _____ <input type="radio"/> PEANUT _____ <input type="radio"/> INSECT STINGS _____ <input type="radio"/> MEDICINE/DRUGS _____ <input type="radio"/> OTHER (SPECIFY) _____		Please list any medications taken on a daily basis, including over-the-counter medications: _____ _____ _____ <i>This health history is complete and accurate. My child has permission to engage in all prescribed activities, except as noted by me. In case of illness or injury, I/we give permission for her to receive first aid, and to receive emergency treatment from a licensed physician, emergency medical services, or other health care professional. It is understood that all reasonable efforts will be made to contact the parent or guardian.</i> SIGNATURE OF PARENT(S)/GUARDIAN _____ DATE _____ <i>This health history is complete and accurate. I am able to engage in all prescribed activities except as noted.</i> SIGNATURE OF ADULT _____ DATE _____		