Youth Health History

Pack #_____

Name_____ Address_____

City_____ State_____ Zip_____+_____

Health/Accident Insurance Company_____ Policy #_____

Have or subject to (**check** if yes): __ Asthma __ Fainting Spells __ Convulsions __ Diabetes

__ Heart Trouble __ Bleeding Disorders __ Allergies to any medication, food, plant, animal, or insect toxin

__ Any condition that requires special care, medication or diet. Explain:_____

_____

Check here if none of the above applies __

Have difficulty with (check if yes): __ Eyes, Ear, Nose, Throat __ Digestion __ Bed-Wetting

__ Lungs __ Sleep Walking

Any condition(s) requiring regular medication? ___ Name of Medication _____

Any restriction of activity for medical reasons: Explain: _____

_____

Date of last tetanus inoculation: _____

Parent Authorization:

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 above. 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 for my son.

Signature:_____ Date_____
(Parent or Guardian)

Home Phone (_____)_____-_____ Business Phone (_____)_____-_____

Adult Health History

Name_____ Address_____

City_____ State_____ Zip_____+_____

Health/Accident Insurance Company_____ Policy #_____

Have or subject to (**check** if yes): __ Asthma __ Fainting Spells __ Convulsions __ Diabetes

__ Heart Trouble __ Bleeding Disorders __ Allergies to any medication, food, plant, animal, or insect toxin

__ Any condition that requires special care, medication or diet. Explain:_____

_____

Check here if none of the above applies __

Have difficulty with (check if yes): __ Eyes, Ear, Nose, Throat __ Digestion __ Bed-Wetting

__ Lungs __ Sleep Walking

Any condition(s) requiring regular medication? ___ Name of Medication _____

Any restriction of activity for medical reasons: Explain: _____

_____

Date of last tetanus inoculation: _____ Are you currently CPR Certified?_____

Signature:_____ Date_____