Year: _____

Health Information Form

Name of Participant_____Date of Birth_____Age_____

Address _____City_____State_____Zip_____

Phone Number (_____)_____Sex_____Height_____Weight_____

Last 4 of Social Security Number: _____

Emergency Contact Person

Parent/Guardian Name_____

Address _____City_____State_____Zip_____

Home Phone Number (_____)_____Work Phone Number (_____)_____

Alternate Contact Person: (Use someone near the primary contact)

Parent/Guardian Name_____

Address _____City_____State_____Zip_____

Home Phone Number (_____)_____Work Phone Number (_____)_____

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while participant is at the activity.
Do you have health insurance?____Yes____No
If NO, initial here in agreement to pay all out of pocket charges that might incur if accident/injury is to happen. _____

Name of Insurance Company_____In whose name is the insurance?_____

Policy Number_____Group Number_____

Family Doctor_____City_____Phone Number_____

If participant should require medical attention for injuries received or illnesses contracted prior to activity, please send us the necessary information to give him/her proper medical care during his/her time with the ministry activity.

Health History:
Pre-existing or present medical conditions (or any special conditions we may need to know about)_____

_____

_____

Name and dosage of any medications that must be taken_____

_____

Any allergies?_____to medications?_____

____Hay Fever___Heart Condition___Diabetes_Asthma___Frequent Stomach Upsets___Insect Stings
____Epilepsy/Nervous Disorders___Physical Handicap___Any major illnesses during the past year?

If any of the above are checked, please give details (i.e., include normal treatment of allergic reactions)

_____

Date of last tetanus shot_____Contact Lenses?_____

Any swimming restrictions?_____Yes____No What?_____

Any activity restrictions? _____Yes____No What?_____

Blood Type_____