HEALTH FORM (Sept 2011- Aug 2012)

Name	Birth date	Age	Sex
Parent or Guardian	Home Phone	Business Phone	
Home Address	City/State	Zip	

IF PARENT NOT AVAILABLE, IN AN EMEREGENCY, NOTIFY:			
1) Name	Phone	City/State	Zip
2) Name	Phone	City/State	Zip
Name of Family Physician			Phone
Family Health Insurance Plan:	Company	Policy #	

HAS THE PARTICIPANT EVER HAD THE FOLLOWING? IF SO, WRITE IN DATE.									
Asthma	Chicken Pox	Convulsions	Diabetes	Ear Infections	German Measles	Heart Murmur	Measles	Mumps	Rheumatic Fever
Operations or Serious Injuries (Dates)									

HAS THE PARTICIPANT EVER HAD AN ALLERGIC REACTION TO:			
Hay Fever	Insect Stings	Penicillin	Ivy Poisoning
Other drugs (specify)	Foods (specify)		
If answer is YES to any allergies, please describe the reaction.			
Chronic or Recurring Illness:			
Other Diseases or Details of Above:			
Any specific activities to be encouraged?			
Restricted?			
Special Diet?		Mouth Braces	
Special Medication (name it)			Is Parent sending it?

IF PARTICIPANT HAS EXPERIENCED EMOTIONAL OR BEHAVIORAL PROBLEMS, PLEASE FURNISH INFORMATION THAT WILL HELP THE LEADERS/CHAPERONS MEET THE NEEDS OF THE PARTICIPANT.			
Is participant a sleepwalker?		A bed wetter?	
(For Girls)	Has she menstruated?	If so, is her menstrual history normal?	If not, has she been told about it?
Special considerations:			

GIVE DATE OF MOST RECENT IMMUNIZATION OR BOOSTER:						
Tetanus	DPT	Measles	Polio	Mumps	Polio	German Measles (Rubella)
Other (specify)						

PARENT/GUARDIAN EMERGENCY AUTHORIZATION

This health history is correct so far as I know, and the person described herein has my permission to engage in all prescribed group activities, except as noted by me and the examining physician, if necessary. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the activity leader to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above. In the event it becomes necessary for that person to give consent for us, we agree to hold such person free and harmless of nay claims, demands, or suits for damages arising from the giving of such consent as long as the treatment is administered by or under the supervision of a licensed physician.

SIGNATURE ____ DATE ______________