

HEALTH HISTORY (Boy)

Please Print

Name _____ Address _____

Health / Accident Ins. Co. _____ Policy # _____

Insured _____ Relationship to Insured _____

Have or subject to: (check if YES)

- | | | |
|---|--|---|
| <input type="checkbox"/> Astma | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Allergy to medication food, plant, animal
or insect toxin |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart trouble | |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Any condition that may require special care,
medication or diet |

Explain: _____

CHECK HERE IF NONE OF THE ABOVE APPLIES []

Any condition now requiring regular medication [] YES [] NO Name of medication _____

Any restriction of activity for medical reasons? [] YES [] NO Explain _____

Immunizations: Tetnus _____ Diphtheria _____ Measles _____

Date of last Polio _____ Pertussis _____ Rubella _____

Innoculations Mumps _____

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 by me. In the event I cannot be reached in an emergency, I here by 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 of parent or guardian _____ Date _____

Home telephone _____ Business telephone _____

HEALTH HISTORY (Adult)

Name _____ Address _____

Health / Accident Insurance Co. _____ Policy# _____

Insured _____ Relationship to Insured _____

Have or subject to: (Check if Yes)

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Allergy to medication, food, plant, animal or
insect toxin |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart trouble | |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Any condition that may require special care,
medication or diet. |

Explain: _____

CHECK HERE IF NONE OF THE ABOVE APPLIES []

Any condition now requiring regular medication [] YES [] NO Name of medication _____

Any restriction of activity for medical reasons? [] YES [] NO Explain _____

Immunizations: Tetnus _____ Measles _____ Pertussis _____

Date of last Mumps _____ Polio _____ Diphtheria _____

Innoculations: Rubella _____

This health history is correct so far as I know. _____

Signed