HEALTH AND MEDICAL RECORD

1. IDENTIFICATION

Name: ______________________ Age: ________ Birth Date ____________
Address: ______________________________ Home Ph: ____________
City: ____________ Prov: ________ PC: ________ ☐Male ☐Female

NAME:

HEALTH HISTORY

*Asthma	______	*Bedwetting	______	*Epilipsey	______
Hay Fever	______	Kidney Disease	______	Rheumatic Fever	______
Sinus Trouble	______	*Constipation	______	Heart Trouble	______
Earache/Ear Infection	______	*Frequent Diarrhea	______	Glasses	______
Ear Tubes	______	*Severe Stomachaches	______	Contact Lenses	______
Fainting Spells	______	Diabetes	______	For Women:	
Tuberculosis	______	*Sleep Walking	______	Menstrual Problems	______

2. ALLERGIES OR ELLERGIC REACTIONS (Check if yes and tell what happens)

- ☐ Penicillin
- ☐ Other Medications (List):
- ☐ Bee Stings
- ☐ Food
- ☐ Poison Oak, Poison Ivy
- ☐ Other: (List)

3. PLEASE LIST ALL SERIOUS ILLNESSES OR OPERATIONS IN THE PAST FIVE YEARS:

Operation or Illness	Date	Hospitalized? Yes/No

4. PLEASE LIST ALL MEDICATIONS CURRENTLY BEING TAKEN:

Medication	Number of times in a Day	Reason for Taking

5. IMMUNIZATION HISTORY

Required Immunizations must be determined locally. This is a record of dates of basic immunizations and most recent booster doses.

DTP Series	______	Booster	______
Polio OPV (Sabin)	______	Booster	______
Measles Vaccine (live)	______		
German Measles (Rubella)	______		
Tetanus Booster	______		
Tuberculin Test	______		
Mumps Vaccine (live)	______		
Chicken Pox	______		

DATE FILLED OUT:

6. DIET

☐ Regular ☐ Diabetic ☐ Low Salt ☐ Low Fat/Cholesterol
☐ Other – Specific Instructions ______________________

7. PHYSICAL ACTIVITY

Any restriction on activity for medical reasons? Explain: ______________________

Any other type of health concerns which might be pertinent? ______________________

8. INFORM IN CASE OF ACCIDENT OR ILLNESS

Parent/Guardian/Spouse ______________________ Home Phone: __________
Home Address ______________________

Work Address ______________________ Work Phone: __________

If not available in emergency notify:
Name __________ Or Name __________
Address __________ Address __________

Home Ph ______ Work Ph ______ Home Ph ______ Work Ph ______

9. DOCTOR TO CONSULT IN CASE OF EMERGENCY

Name ______________________ Phone ( ) __________
Address ______________________ City __________
Prov __________ PC __________

10. DO YOU HAVE

☐ Medical Insurance Number __________ Type Coverage __________
☐ Which? Company Name ______________________
Information above is correct to the best of my knowledge

Date ______________________ Signed ______________________
Parent or Guardian

PARENT'S AUTHORIZATION –required for those under 18 years of age.

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 and the physician. 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 anaesthesia, or to order injection or surgery for my son or daughter. A photocopy of this shall form be as valid as the original.

Suggestions from Parents ______________________

Signature ______________________ Date __________
Parent or Guardian