Health History

Event Name: ________________________________ Date: _________ Year: ________________________

Participant's Name: ____

Please complete the following history as possible. A health examination by a physician is only necessary if a participant has been exposed to a contagious disease or is recovering from severe injury or illness. This information will enable a healthcare facility to treat you/your child with minimum delays in case of an emergency. Adult participants should also complete this form.

Allergies/Health Problems (check and date)

☐ ___ Anorexia/Bulimia ☐ _________ Asthma ☐ _________ Convulsions ☐ _________ Diabetes

☐ ___ Ear infection ☐ _________ ADD/ADHD ☐ _________ Lethargic ☐ _________ Rheumatic Fever

List all allergies (food and medication) ____

____

Operations or serious injuries ____

Chronic or recurring illness and/or concerns of a physical or emotional nature (Please be Specific.) ________________________

____

Date of last Physical ____________________________ General Health Appraisal ____________________________

Date of last tetanus shot _________________________ Are all immunizations up-to-date? _______________________

List any restrictions____

Special dietary needs____

Are there any other concerns of which the staff should be made aware? ____________________________________

Health and Accident Coverage

Participants will be covered by a health/accident policy that will pay for the first $250 of health care, and the balance over that amount is not collectible from the users' other insurance coverage up to policy limits.

_________________________________ _________________________________ ☐ group ☐ individual

Insurance Company Policy Number Type of Policy

_________________________________ _________________________________

Name of Policy holder Parent/Guardian, Social Security Number (requested by hospital)

____

Policy holder's Employer and Employer's Address

Authorization for Medical Treatment

In registering for this event the parent/guardian/person authorizes the Illinois Great Rivers United Methodist Conference to secure medical treatment for this participant in case of any illness or accident for which the Coordinator or first-aid personnel feels professional medical attention is required. I hereby give permission to the physician selected by the Coordinator/first-aid personnel/designated staff member to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for me/my child as named.

____ ________________ ________________

Signature of Parent/Guardian/Participant of legal age Relationship Date

Family Physician ____

Physician's Address ____

Please list any special medical, dietary, or physical needs: _______________________________________

In Case of Emergency, Notify

1. Grandparent/Relative/Friend ______________________________ Phone (____) ____________________

____

Street & Number City State Zip

2. Grandparent/Relative/Friend ______________________________ Phone (____) ____________________

____

Street & Number City State Zip