

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.

_____ Insurance Company _____ Policy Number group individual
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