

PERSONAL INFORMATION:

Name (Last, First, Middle Initial) _____			
Birthdate (mm/dd/yy) _____	Age _____	Sex _____	
Street Address _____			
City _____		State _____	Zip _____
Home Phone _____		Other Phone _____	

IN CASE OF EMERGENCY NOTIFY:

Name (First and Last) _____	Relation _____
Address _____	Phone _____

INSURANCE INFORMATION, PLEASE COMPLETE THE FOLLOWING:

Carrier _____	ID Number _____	Group Number _____
Member Services Phone _____	Address _____	

HEALTH HISTORY (CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING):

<input type="checkbox"/> Eyesight impairment	<input type="checkbox"/> Disease of kidneys	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Disease of ears
<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Intestinal disorders
<input type="checkbox"/> Speech impairment	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Disorders of nervous system	<input type="checkbox"/> Abnormal blood pressure	<input type="checkbox"/> Hernia	<input type="checkbox"/> Measles
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Mental or emotional disorders	<input type="checkbox"/> Asthma or Hay Fever	<input type="checkbox"/> Mumps
<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Severe menstrual pain	<input type="checkbox"/> Other serious allergies	<input type="checkbox"/> German Measles
<input type="checkbox"/> Other _____			

 Have you been hospitalized in the last five years? Yes No

 Are you taking any medication? Yes No

IF YOU HAVE CHECKED OR ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE GIVE THE FOLLOWING INFORMATION:

Nature of Illness	Dates Afflicted (start - end)	Period of Disability	Results/Outcome

PLEASE LIST CURRENT MEDICATIONS BEING TAKEN, BELOW:

Medication	Dosage (how much, how many times a day)	Potential Harmful Interactions (food, other medications, environment)

I certify that, to the best of my knowledge, this health history is complete and accurate. I am in good health and able to participate in this event/assignment.

Signature of Applicant _____ Date _____

HEALTH INFORMATION PRIVACY STATEMENT

The **Health History Record** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. Sybaquay Council will retain the health form until it is destroyed. All forms/records with noted treatment will be retained for seven years. Access to the information will be limited, but the participant or their legal representative may request copies from the event sponsor. I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Signature of Applicant _____ Date _____