

HEALTH AND MEDICAL RECORD

NAME:

1. IDENTIFICATION

Name: _____ Age: _____ Birth Date _____
 Address: _____ Home Ph: _____
 City: _____ Prov: _____ PC: _____ Male Female

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 ALLERGIC REACTIONS (Check if yes and tell what happens)

<input type="checkbox"/> Penicillin	_____
<input type="checkbox"/> Other Medications (List):	_____
<input type="checkbox"/> Bee Stings	_____
<input type="checkbox"/> Food	_____
<input type="checkbox"/> Poison Oak, Poison Ivy	_____
<input type="checkbox"/> 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 form shall be as valid as the original.

Suggestions from Parents _____

Signature _____ Date _____

Parent or Guardian