NHUMC
Participant Health Form
2010

(Each child will be required to have this form in their folder before they will be able to participate in any youth activity.)

Name:_____
Last First Middle
Address:_____ City:_____ Zip:_____

Birthdate:_____ Grade in School:_____ **Update** _____
Month Day Year

Update _____ **Update** _____

Home Phone:_____
Parent/Guardian:_____ Daytime Phone:_____Eve. Phone:_____
Parent/Guardian:_____ Daytime Phone:_____Eve. Phone:_____
If my parent is not available in an emergency, notify:
_____Phone:_____Phone:_____

HEALTH HISTORY: (Circle—giving approximate dates)
Diseases/Illnesses:

*Asthma	_____	*German Measles	_____	* Mono	_____
*Bleeding Disorder	_____	*Heart Problems	_____	*Mumps	_____
*Cancer	_____	*High Blood Pressure	_____	*Recurring Strep Inf.	_____
*Chicken Pox	_____	*Hypoglycemia	_____	*Respiratory Problems	____
*Diabetes	_____	*Kidney Problems	_____	*Ear Infections	_____
*Knee Problems	_____	*Eating Disorders	_____	*Measles	_____

ALLERGIES:

*Hay Fever	_____
*Insect Stings	_____
*Ivy Poisoning	_____
*Other	_____

Drug Allergies: (List any medication you are allergic to.)
_____
_____
_____
_____

Have you been out of the USA in the past 9 months? _____ If so, Where?_____
Update—Have you been out of the USA in the past 9 months? _____ IF so, Where? _____
Update—Have you been out of the USA in the past 9 months? _____ IF so, Where? _____
IMMUNIZATIONS:
***Tetanus—Date of Last Tetanus:_____(Obtain Tetanus if you are not current)**
Have you been (in the past 12 months) or are you currently being treated for a psychiatric/psychological disorder? _____

If yes, please explain:_____

_____
List any previous surgeries or injuries (Give Dates):_____
_____
Any illness occurring within the last 5 years that caused you to miss school or work for more than 3 days:
_____

MEDICAL INSURANCE:
I am covered under my parents' Medical Insurance Plan: _____Yes _____No
If so, name of Insurance Company:_____
I have Medical Insurance of my own: _____Yes _____No
If so, name of Insurance Company: _____
Primary Care Physician:_____ Phone #:_____
Last First

***A copy of your insurance card is required ***

CONSENT FOR TREATMENT:
I hereby give permission to the physician selected by NHUMC to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child/myself. (Circle one) (Guardian signature required if under 18 years of age.)

Signature:_____ Date:_____

Update _____ **Initial** _____

****You will be asked to update this form each year.** **Update** _____ **Initial** _____