ADULT HEALTH HISTORY

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):

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

☐ 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 __________