

**PERSONAL HEALTH AND MEDICAL HISTORY**

To be filled out by parent, guardian, or adult participant. Please type or print legibly in ink.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Medical Conditions/ Allergies:

Activity & Dietary Restrictions:

List all Medications you are currently taking:

Parent / Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Cell: \_\_\_\_\_ Pager: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**If parent or guardian is not available in the event of an emergency, notify:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Health/Accident Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

In case of emergency, I understand that every effort will be made to contact me (if an adult, my spouse or next of kin). In the event that I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for myself if participant is an adult).

Signature of parent/guardian: \_\_\_\_\_