



RECORD OF MEDICAL HISTORY AND INSURANCE 2012

For our records and your protection, please complete both pages of this form, supplying **ALL** requested information. This form requires your signature and that of your parent or legal guardian. The information on this form will be kept confidential.

PLEASE TYPE OR PRINT CLEARLY

NAME: _____ DATE OF BIRTH: _____

FEMALE: ___ MALE: ___ PLACE OF BIRTH: _____ PHONE #: _____

MAILING ADDRESS: _____

Parent, Legal Guardian or person to notify in case of accident or emergency:
 _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE # _____

FAMILY PHYSICIAN: _____ PHONE # _____

PERSONAL HISTORY

I. Check the following diseases you have had:

Allergies _____ Diphtheria _____ German Measles _____ Mononucleosis _____ Pneumonia _____ Tonsillitis _____

Bleeding Tendencies _____ Diabetes _____ Heart Disease _____ Mumps _____ Rheumatic Fever _____ Polio _____

Chicken Pox _____ Epilepsy _____ Measles _____

II. Check the following conditions you have had or are subject to now or in the past:

	Past	Current		Past	Current		Past	Current
Asthma	_____	_____	Migraine	_____	_____	Digestive Upsets	_____	_____
Ear Infection	_____	_____	Nose Bleeds	_____	_____	Convulsions	_____	_____
Hay Fever	_____	_____	Hearing Loss	_____	_____	Dizzy Spells	_____	_____
Headaches	_____	_____	Visual Loss	_____	_____	Fainting Spells	_____	_____
						Difficulty Sleeping	_____	_____

Are you currently taking medication(s) for any of the above conditions? Yes _____ No _____ If "Yes", please list below the name of the medication(s) and for what condition(s):

Name _____ Date of Birth _____

ADDITIONAL REMARKS (including past hospitalization and major injuries):

MEDICATION

I. Have you had a bad reaction to any of the following? and if so when:

Penicillin _____ Sulfa Drugs _____

Horse Serum (tetanus) _____ Any other drugs _____

Insect Stings or bites _____ Foods _____

II. If you are you allergic to any drugs or foods? Please list:

III. In addition to medication listed on page one, are you taking additional medication of any kind? Please list name, dosage, and condition:

IV. Do you require any special dietary considerations? Please explain:

IMMUNIZATIONS

Date of Last Tetanus shot: _____ Date of Hepatitis B Immunization: _____

GENERAL

If there are any limitations on the amount of physical exercise you can engage in, please describe and explain:

In accordance with the risk management policies of the COLS participants in programs and activities must complete this form and return it as indicated with the other forms in the registration kit. Please provide your private health insurance company, group or individual health plan or major medical number and carrier name, to be given to a doctor or a medical facility in the event of illness or injury.

Name of carrier: _____

Plan name and number: _____

- and -

Health Card Number: _____

Date: _____ Signature of Participant: _____

Signature of Parent or Legal Guardian: _____