Health and Medical Record

1. IDENTIFICATION (Please print)

Name: _____ Age: ____ Birth Date: _____ Male: ____ Female: ____
Address: _____ City: _____ State: ___ Zip: _____
Social Security #: _____ Home Phone: _____ Religion: _____

2. HEALTH HISTORY

Have you had: Mark (Past) "P" and/or (Now) "N" or leave blank.

☐P ☐N Stroke/Paralysis
☐P ☐N Seizures
☐P ☐N Fainting Spells
☐P ☐N Eye Trouble
☐P ☐N Glasses/Contacts
☐P ☐N Earaches/Infection
☐P ☐N Sinus Trouble
☐P ☐N Lung Disease
☐P ☐N Asthma
☐P ☐N Heart Trouble
☐P ☐N High Blood Pressure
☐P ☐N Kidney Disease
☐P ☐N Liver Disease
☐P ☐N Diabetes
☐P ☐N Gastrointestinal Pain/Disease
☐P ☐N Urinary Problem
☐P ☐N Back Pain/Injury
☐P ☐N Joint Pain/Injury
☐P ☐N Circulation Problem
☐P ☐N Menstrual Problems (women)

Are you pregnant? ☐ Yes ☐ No If yes, when is your due date?

_____

Clarify any items marked above: _____

_____

_____

3. ALLERGIES OR ALLERGIC REACTIONS (Check if yes and explain what happened)

☐ Penicillin: _____
☐ Other Medications (list) _____
☐ Bee Sting _____
☐ Food (what types?) _____
☐ Other: List to what and give reactions

_____ _____
_____ _____
_____ _____

4. PLEASE LIST ALL OPERATIONS OR SERIOUS ILLNESSES

Operations or Illness:	Date:	Hospitalized: (yes/no)

5. PLEASE LIST ALL MEDICATIONS CURRENTLY BEING USED

Medication	Dose	Number of Times a Day	Reason for Taking

6. IMMUNIZATION HISTORY

This is a record of dates of basic immunizations and most recent booster doses.

DPT Series _____
Polio OOPV (Sabin) _____
Measles Vaccine (live) _____
Rubella _____
Tetanus Booster _____
Tuberculin Test _____
Mumps Vaccine (Live) _____
Chicken Pox _____
Hepatitis A _____
Hepatitis B _____

Continuation of Health and Medical Record

7. DIET

☐ Regular ☐ Diabetic ☐ Low Salt ☐Low fat/Cholesterol

☐ Other – Special Instructions: _____

8. PHYSICAL ACTIVITY

Are there any restrictions to your activity for medical reasons? Explain: _____

_____

Any other type of health concerns which might be pertinent: _____

_____

_____

_____

9. IN CASE OF ACCIDENT OR ILLNESS, CONTACT:

Parent/Guardian/Spouse: _____ Cell Phone: ( )_____

Home Address: _____

_____ Home Phone: ( )_____

Work Address: _____

_____ Work Phone: ( )_____

10. DOCTOR TO CONSULT IN CASE OF EMERGENCY

Name: _____ Office Phone: ( )_____

Address: _____ Specialty: _____

_____

11. MEDICAL INSURANCE INFORMATION

Primary Insurance Co. _____ I.D. #: _____

Address: _____ Group #: _____

_____ Phone #: ( )_____

Secondary Insurance Co. _____ I.D. #: _____

Address: _____ Group #: _____

_____ Phone #: ( )_____

The information above is correct to the best of my knowledge.

Signed: _____ **Dated:** _____

I give Adventist Community Services Management permission to release the above information to a medical facility and/or physicians in the event I become ill or injured.

Signed: _____ **Dated:** _____

PARENT/GUARDIAN AUTHORIZATION FOR VOLUNTEERS UNDER 18 YEARS OF AGE

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed activities, except those noted by me or a physician. In the event I cannot be reached in an emergency, I hereby give permission to the physicians selected by Adventist Community Services Management to hospitalize, secure proper anesthesia, or to order injection or surgery for my son/daughter. A copy of this document shall be as valid as the original.

Signed: _____ Dated: _____

(Parent or Guardian)

Print Name: _____