MEDICAL HISTORY / Participant and/or Adult   Inside Out

School or Group: ________________________________

Participant:__________________________________Age:________________DOB:_______________
Sex: M / F Address:____
Contact Person(s)
Name:____ Relationship: ________________________
Home #: ________________________ Work #: ________________________
Name:____ Relationship: ________________________
Home #: ________________________ Work #: ________________________

Mark each of the following items with regard to whether the participant currently has, or in the past has had, the condition. Use the space provided at the end to explain any "yes" answers. If the answer is "not in a while", mark "yes" and give approximate date since last occurrence: Please elaborate if necessary --on the back of this form.

yes / no
1. Allergic to insect bites or stings..___ / ___
2. Asthma..___ / ___
3. Bones/joints weakened by injury or illness...___ / ___
4. Heart Conditions...___ / ___
5. High blood pressure..___ / ___
6. Medical care which limits activities..___ / ___
7. Mental or emotional disorders...___ / ___
8. Migraine headaches..___ / ___
9. Motion Sickness..___ / ___
10. Seizures...___ / ___
11. Last Tetanus shot Date.. ___/___/___
12. Any Other not covered by items 1-10..____
____

12. List in this space medicines to which participant is allergic: (please add severity)
____

13. Please list specific food allergies and their severity. (can they be around it? Ingest only reaction?)
____

14. List in this space medicines which participant is currently taking for ANY reason, whether prescribed, or over the counter:____
____

15. Does the parent or legal guardian allow the minor participant to receive non-prescription medicine for incidental headaches, sore throats, and/or upset stomachs, which may occur while participant is away from home.____
16. Does the parent or legal guardian allow the minor participant to receive such treatment as may be immediately necessary in an emergency or life threatening situation?____________
17. Insurance Company Name ____
Insurance policy number ____

Signature:____Date:__________________
Relationship to above named:____