Adult Health & Emergency Medical Authorization Form

NAME:	BIRTHDATE:	
ADDRESS:	HOME PHONE:	
CITY:	STATE: ZIP:	
Immediate Family Contact:	Phone:	
Address:	Relationship:	
Family Health Ins. Co.	Policy #:	
Family Physician :	Phone:	
Dentist:	Phone:	

IMMUNIZATION RECORDS

_	1	1			
Immunization	Year Primary	Year of Last	Immunization	Year Primary	Year of Last
	Series Completed	Booster		Series Completed	Booster
DPT			Oral Polio		
ТВ			Meningococcal		
MMR			PCV7		
Hib			Varicella		
Нер В			Tetnus		

HEALTH HISTORY

• Allergies:
Childhood Diseases:
Special Problems or Significant Illness:
Special Diet:
Activity restrictions:
Medications to be taken while at activity:
Comments/Suggestions:
Operations or Hospitalizations (include year):
Recent illness or exposure to contagious disease? Yes No
Details:

CONSENT: This health history is complete and accurate. I know of no reason (s), other than the information indicated on this form, why I should not participate in prescribed activities except as noted. I give permission to receive routine health care, over the counter drugs, and prescription drugs administered by appropriate staff, emergency medical and surgical treatment, and to be hospitalized if necessary. In the event of an emergency it is understood that every effort will be made to reach my immediate family contact. It is understood this consent is given in advance of any specific diagnosis or treatment being required but is given to encourage the program leader and said physicians to exercise her/his best judgment as to requirements of such diagnosis or treatment. This permission shall remain in effect from ______ to _____ unless sooner revoked in writing by myself.

SIGNATURE (REQUIRED)

Date