

Riverwood District Event Health and Medical Record

Name _____ Date of Birth _____

Address _____ Unit Number _____ Youth ___ Adult ___

City _____ State _____ Zip _____

Family Medical Insurance Co. _____ Policy Number _____

In Case of Emergency, Please Notify:

Name _____ Relationship _____

Address _____

Home Phone _____ Cell Phone / Pager _____ Other _____

Special Instructions _____

Health History

To be completed and signed by parent / legal guardian for participant under 18 years of age, or adult participant for themselves.

Have had or subject to: (Check if Yes)

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Frostbite | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hypothermia | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Earache / ear infection | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Severe Stomachaches | <input type="checkbox"/> Allergy or reaction to any medication | <input type="checkbox"/> Other | |

Please describe any marked items:

Have difficulty with: (Check if Yes)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Eyes, ears, nose, throat | <input type="checkbox"/> Lungs, breathing | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Condition | <input type="checkbox"/> Menstrual Problems (females) |

Any condition(s) now requiring regular medication? ___ Yes ___ No Medication(s): _____

Note: Please include the names of all medications, as well as their instructions and prescribed dosages.

Any restrictions of activity for medical reasons? Please explain: _____

Please list any allergies (food, medication, etc.): _____

Information above is correct to the best of my knowledge. I meet the age requirements for the program I will be participating in.

Participant's Signature _____ Date _____

Parent's Authorization - Required for those under 18 years of age.

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted. In the event I cannot be reached in an emergency, I hereby give permission to the physician, selected by the adult leader in charge, to hospitalize, secure proper anesthesia, or to order injection or surgery for my minor child.

Parent or Legal Guardian Signature _____ Date _____