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

Immunization	Year Primary Series Completed	Year of Last Booster	Immunization	Year Primary Series Completed	Year of Last Booster
DPT			**Oral Polio**		
TB			**Meningococcal**		
MMR			**PCV7**		
Hib			**Varicella**		
Hep B			**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**