

SERVICE OVER SELF

PARTICIPANT HEALTH FORM

Name: _____

Last

First

Middle

Permanent Address: _____

Home Phone: _____ Social Security # _____

Parent/Guardian: _____ Daytime Phone: _____ Eve. Phone _____

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If my parent is not available in an emergency, notify:

_____ Phone: _____ Phone: _____

_____ Phone: _____ Phone: _____

Health History: (Check - giving approximate dates)

Diseases/Illnesses:

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> German Measles _____ | <input type="checkbox"/> Mono _____ |
| <input type="checkbox"/> Bleeding Disorder _____ | <input type="checkbox"/> Heart Problems _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Recurring Strep Inf. _____ |
| <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Hypoglycemia _____ | <input type="checkbox"/> Respiratory Problems _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Kidney Problems _____ | <input type="checkbox"/> Respiratory Problems _____ |
| <input type="checkbox"/> Ear Infections _____ | <input type="checkbox"/> Knee Problems _____ | |
| <input type="checkbox"/> Eating Disorders _____ | <input type="checkbox"/> Measles _____ | |

Allergies:

- Hay Fever _____
- Insect Stings _____
- Ivy Poisoning _____
- Other _____

Drug Allergies: (List any medication you are allergic to)

Have you been out of the USA in the past 9 months? _____ If so, where? _____

Immunizations:

Tetanus – Date of Last Tetanus: _____ (Obtain Tetanus if you are not current)

Have you been (in the past 12 months) or are you currently being treated for a psychiatric/psychological disorder? _____

If yes, please explain: _____

List any previous surgeries or injuries (Give Dates): _____

Any illness occurring within the last 5 years that caused you to miss school or work for more than 3 days: _____

I am covered under my parents' Medical Insurance Plan: ___ Yes ___ No

If so, name of Insurance Company: _____

I have Medical Insurance of my own: ___ Yes ___ No

If so, name of Insurance Company: _____

Insurance Policy #: _____ Insurance Policy Phone #: _____

Consent for Treatment

I hereby give permission to the physician selected by the SOS Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for myself. (Guardian signature required if under 18 years of age).

Signature: _____ Date: _____