SOS114

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:

☐ Asthma	_____	☐ German Measles	_____	☐ Mono	_____
☐ Bleeding Disorder	_____	☐ Heart Problems	_____	☐ Mumps	_____
☐ Cancer	_____	☐ High Blood Pressure	_____	☐ Recurring Strep Inf.	_____
☐ Chicken Pox	_____	☐ Hypoglycemia	_____	☐ Respiratory Problems	_____
☐ Diabetes	_____	☐ Kidney Problems	_____	☐ Respiratory Problems	_____
☐ Ear Infections	_____	☐ Knee Problems	_____		
☐ Eating Disorders	_____	☐ 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 mare 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 SOS114 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: _____