HEALTH AND MEDICAL RECORDS

Name _____ Age _____ Birth Date _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Male ☐ Female ☐

Adventurer Club Name _____

Health History Have you had or currently have:

Past	Now		Past	Now		Past	Now		Past	Now	
☐	☐	Asthma ..	☐	☐	Earache/Ear Trouble	☐	☐	Glasses	☐	☐	Fever
☐	☐	Bed wetting	☐	☐	Ear Tubes	☐	☐	Hay Fever	☐	☐	Severe Stomachaches
☐	☐	Constipation	☐	☐	Epilepsy	☐	☐	Heart Trouble	☐	☐	Sinus Trouble
☐	☐	Contact Lenses	☐	☐	Fainting Spells	☐	☐	Kidney Disease	☐	☐	Sleep Walking
☐	☐	Diabetes	☐	☐	Frequent Diarrhea	☐	☐	Menstrual Problems (For Women Only)	☐	☐	Tuberculosis

Allergies or Allergic Reactions (Check if yes and tell what happened)

☐ **Medications** _____

☐ **Bee Sting** _____

☐ **Food** _____

☐ **Poison Oak/Ivy** _____

☐ **Other Allergies (list)** _____

Please List All Serious Illnesses or Operations in the Past Five Years

Operation or illness	Date	Hospitalized (yes or no)
_____	_____	
_____	_____	

Please List All Medications Currently Being Taken

Medication	Date	Reason for Taking
_____	_____	_____
_____	_____	_____

Physical Activity

Any restriction of activity for medical reasons? Explain _____

_____

Any other types of health concerns, which might be pertinent? _____

_____

Any unusual behaviors (nightmares, sleep talking) _____

Immunization History

Required immunizations must be determined locally. This is a record of basic immunizations and most recent Boosters.

Check	Date	Check	Date
☐ Measles Vaccine (live)	_____	☐ Tetanus Booster	_____
☐ German Measles (Rubella)	_____	☐ Tuberculin Test	_____
☐ DPT Series	_____ Booster _____	☐ Chicken Pox	_____
☐ Polio OPV (Sabin)	_____ Booster _____	☐ Mumps Vaccine (live)	_____

Oregon Residents: Does your child meet current Oregon State law for school attendance? ☐ Medical Exemption ☐ Religious Exemption

Diet ☐ Regular ☐ Diabetic ☐ Low Salt ☐ Low Fat/Cholesterol ☐ Vegan ☐ Other _____

Inform in Case of Accident or Illness

Parent/Guardian/Spouse _____

Home Address _____Home Phone _____

Work Address _____Work Phone _____

If contact listed above is not available, in emergency notify:

Name_____ Name _____

Address _____ Address _____

_____ _____

Phone: Home _____ Work _____ Phone: Home _____ Work _____

Doctor to Consult in Case of Emergency

Name _____ Address_____

City _____ State _____ Zip _____Phone_____

Do You Have

Medical Insurance? _____ if yes, please provide Insurance Number _____
(Yes or No)

Insurance Name _____

PARENT'S AUTHORIZATION-required for those under 18 years of age or under 21 if still living at home.
This health history is correct so far as I know, and the child named above has permission to engage in all activities, except as noted herein by me. Exceptions (if any) _____. In the event I cannot be reached in an emergency, I hereby give permission to the medical provider selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injections or surgery for my child. A photo copy of this shall be as valid as the original.

Signature _____ Date _____
Parent or Guardian