International Partners Cassie Stern Memorial, Inc.

CONFIDENTIAL MEDICAL HISTORY

Instructions: 1. Complete both pages of this form 2. Sign at the bottom of this page 3.Return to program coordinator

GENERAL INFORMATION

Name ______________________________ Age ______________________

Home Address ______________________ ______________ _____ __________
(Street & Number) (City) (State) (Zip)

Home Phone ( ) ______________ Birthdate ______________________

____ Male _____ Female Family Physician ______________________

______________________________ ( ) ______________________
(Physician's Full Address) Area Code & Phone Number)

Parent /Guardian ______________________ Home Phone ( )______________________

Person to be notified in case of emergency ______________________cell ( )______________________

Email:______________________ Home ( ) ______________________

Business Phone ( ) ______________ Ext.__________ Relationship______________________

Please furnish the following information about your family's health/hospitalization insurance.

Name of Insurance Company: ______________________________________

Address of Insurance Company:______________________________________

Subscriber: ______________________________________

Certificate/Policy Number: ______________________ Group Number______________________

MEDICAL TREATMENT AUTHORIZATION

The IP program staff must have permission to secure medical care for IP participants. These services include x-rays, laboratory tests and emergency care.

The authorization needed is for the use of these services when deemed advisable by the staff during IP work-service trips, in the absence of the parent. In the event of any other than routine medical problems, we will make every effort to advise parents/guardians immediately.

If under 18 years of age, the signature below must be of the parent or guardian. If over 17 years of age, the participant should sign for him/herself.

I HEREBY GIVE PERMISSION TO THE STAFF or VOLUNTEERS OF IP TO SECURE EMERGENCY MEDICAL AND SURGICAL TREATMENT AND ROUTINE NONSURGICAL MEDICAL CARE FOR:

____
(Name of Participant)

Date: ______________________ Signature ______________________________

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Name ____ Height ___________ Weight ________________

HEALTH HISTORY (Check **all** that may apply)

Chickenpox	Asthma	Skin problem
Measles	Heart problem	Diabetes
German Measles	Stomach/bowel problem	Attention Deficit Disorder
Mumps	Constipation	Emotional problem
Whooping Cough	Kidney problem	Behavior problem
Rheumatic fever	Urinary tract infections	Dental problem
Tuberculosis	Arthritis	Vision problem
Frequent sore throats	Frequent headaches	Hearing problem
Recurrent ear infections	Epilepsy/seizures	Other
Sinusitis	Sleep walking	

Other health problems or details on the above:

____

____

IMMUNIZATIONS Give the dates of latest inoculation or booster

_____ DPT series _____ Tetanus Booster ____ Typhoid ____ Malaria meds
_____ Polio series _____ Rubella ____ Hep A ____ Hep B
_____ Measles _____ Smallpox
_____ Tuberculin Test Type _____________Result _____________

Do you have any **allergies**? If yes, describe reaction, recommended precautions and treatment.

Medications (e.g. penicillin) ____

Foods (e.g. shellfish ____

Insect bites (e.g. bee stings) ____

Plants (e.g. poison ivy) ____

Other (e.g. materials.) ____

Are you currently being treated for any health problem? Yes ____ No ____

If yes, for what and by whom? ____

____

What **medications**, if any, are you presently taking? State dosage and frequency needed. None ____

(Please bring enough to cover your stay.)

____

____

Other information we should know to provide you with a safe experience:

____

____

Vegetarian: Yes ____ No ____