

CONFIDENTIAL MEDICAL HISTORY

- Instructions:
1. Complete both sides 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 _____

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 _____