



PERSONAL HEALTH AND MEDICAL HISTORY

To be filled out by parent, guardian, or adult participant. Please print in ink.

IDENTIFICATION INFORMATION:

Name _____
 D.O.B.(MM/DD/YY): ____ / ____ /19____ Age _____ Sex _____
 Name of parent or guardian _____
 Telephone _____
 Home Address _____ Apt # _____
 City _____ Zip _____
 Work Address _____ Apt # _____
 City _____ Zip _____

EMERGENCY CONTACT INFORMATION:

If person named above is not available in the event of an emergency, notify:

Name _____
 Relationship _____ Telephone _____
 Name _____
 Relationship _____ Telephone _____
 Name of personal physician _____
 Telephone _____



GENERAL INFORMATION:

Check all items that apply, **past or present**, to your health history.

CIRCLE Yes / No and explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes / No

Explain: _____

ADHD (Attention-Deficit Hyperactivity Disorder) Yes / No

Convulsions/seizures Yes / No **Asthma** Yes / No **Hemophilia** Yes / No

High blood pressure Yes / No **Cancer/leukemia** Yes / No

Heart trouble Yes / No **Kidney Disease** Yes / No **Diabetes** Yes / No

Other: _____

Explain: _____

List any **medications to be taken at GMAX**, including drug, dosage, route (oral, injection, etc.), and frequency:



List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games:

Immunizations: (Give date of last inoculation.)

Tetanus toxoid _____ Measles _____

Polio _____ OR DPT _____

OR MMR _____

Hepatitis A _____ Varicella _____

OR Chicken pox _____

Hepatitis B _____