Pennsylvania Lions All-State Band
Health Information

NAME ***Last*** ______________________________ ***First*** ______________________________ ***Middle*** _________________________

HOME ADDRESS ____

HOME PHONE ____ ***DATE OF BIRTH*** ____________________________________

SOCIAL SECURITY # ____ ***GENDER:*** ❑ ***Male*** ❑ ***Female***

Emergency Contacts

NAME OF EMERGENCY CONTACT #1 ____ ***PHONE #*** ________________________

Addr of emergency contact #1 ____ ***Relationship*** _____________________

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NAME OF EMERGENCY CONTACT #2 ____ ***PHONE #*** ________________________

Addr of emergency contact #2 ____ ***Relationship*** _____________________

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Insurance Information

DO YOU HAVE HEALTH INSURANCE? ❑ ***Yes*** ❑ ***No***

NAME OF INSURANCE COMPANY ____ ***PHONE #*** _________________________________

Name of Insured / Relationship ____ ***ID & GROUP #s*** _____________________________

Family Physician ___________________________________ ***Phone # for Family Physician*** ____________________________________

I hereby grant permission for the administration of appropriate medical treatment for any illness of or accident to the above-mentioned tour participant while he/she is participating in the project. I agree that all such health information may be shared with and used by tour leaders and attending physicians on the participant's behalf.

_______________________________________ _______________________________________

Signature of Participant *Signature of Parent/Guardian*
(if participant is under 18 years of age)

_______________________________________ _______________________________________

Date *Date*

Personal Medical History

Please complete each line. If no condition exists, please write *none* on those lines.

1. LIST ALLERGIES TO ANY OF THE FOLLOWING.

Medications ____

Environment (food, insects, etc.) ____

Other ____

2. LIST ANY ILLNESS OR MEDICAL CONDITION FOR WHICH YOU ARE CURRENTLY BEING TREATED.

Condition ____________________ ***Year Diagnosed*** __________ ***Treatment*** ____________________

Condition ____________________ ***Year Diagnosed*** __________ ***Treatment*** ____________________

3. LIST ANY REASONS FOR WHICH YOU'VE BEEN HOSPITALIZED OR OPERATED UPON.

Reason ________________ ***Hospital*** ______________ ***Doctor*** ____________ ***Date*** __________

Reason ________________ ***Hospital*** ______________ ***Doctor*** ____________ ***Date*** __________

4. LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (include over-the-counter medication and allergy serum).

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5. EXAMINE THE FOLLOWING LIST AND NOTE WHETHER OR NOT YOU HAVE BEEN DIAGNOSED WITH OR SUFFER FROM ANY OF THE FOLLOWING PROBLEMS BY MARKING YES OR NO. PLEASE COMMENT ON ALL "YES" ANSWERS IN THE SPACE BELOW.

Condition	Yes	No	Condition	Yes	No
Anemia	❑ Yes	❑ No	Rheumatic Heart Disease	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No
Bleeding Disorders	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No
Chicken Pox	❑ Yes	❑ No	Kidney Problems	❑ Yes	❑ No
Cancer (Hodgkin or Leukemia)	❑ Yes	❑ No	Seizures (Epilepsy)	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Sickle Cell Trait	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No	Stomach Ulcers	❑ Yes	❑ No
Migraine Headaches	❑ Yes	❑ No	Tuberculosis (or exposure to)	❑ Yes	❑ No
Hearing Loss (complete/partial)	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
			Other	❑ Yes	❑ No

6. COMMENT ON ALL "YES" ANSWERS LISTED ABOVE. GIVE DATES AND ANY LIMITATIONS AS A RESULT OF 'YES' ANSWERS.

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7. Note here any information on personal conditions that you think might affect your health or safety during the project and of which the Project Leader should be aware. You have the right not to disclose any personal information.

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