

Pennsylvania All-State Lions 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 _____

NAME OF EMERGENCY CONTACT #2 _____ PHONE # _____

Addr of emergency contact #2 _____ Relationship _____

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).

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.

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

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

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.

