



PERSONAL HEALTH AND MEDICAL RECORD

I. IDENTIFICATION

Age: _____ Sex: _____ Date of Birth: Month Day Year

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ E-mail: _____

Mothers Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Business Phone: _____

Fathers Name: _____

Street Address (if different): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Business Phone: _____

II. EMERGENCY MEDICAL INFORMATION

Personal Physician or Family Doctor: _____

Phone: _____

Family Health Insurance Company: _____

Policy Number: _____

Phone: _____

Is Insurance Company pre-authorization required prior to admission to hospital or emergency room?

Yes No If yes, phone #: _____

II. IN AN EMERGENCY PLEASE NOTIFY

Name: _____ Relationship _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Business Phone: (____) _____

III. MEDICAL HISTORY

Parent (or applicant if over 18): Be sure to include any emergency information and restriction or special care that should be observed.

Date of most recent complete physical examination (month and year) _____ 20____

Give full details below for any "Yes" answers.

Are you aware of any **Current Health Problems?** Yes No

Explain _____

Are you currently under medical care or **Taking Medicines?** Yes No

Explain _____

Has there been any **Surgery, Injury, Illness, Allergy or Change in Health** status since last complete physical examination? Yes No

Explain _____

Are you allergic to any **Medicine, Food, Plant, Animal, or Insect Toxin?** Yes No

Explain _____

Do you suffer from conditions such as **Asthma, Convulsions, Heart Trouble, Diabetes, and Bleeding Disorders?** Yes No

Explain _____

Please explain *ANY* health concerns that are not addressed with the questions above: (use additional sheet if necessary)

IV. IMMUNIZATIONS

	Last Year Received	Has had	Vaccination	Disease
Tetanus	_____	Measles	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	_____	Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Polio	_____	Rubella	<input type="checkbox"/>	<input type="checkbox"/>
		Pertussis	<input type="checkbox"/>	<input type="checkbox"/>
		Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>

PARENTAL STATEMENT

To the best of my knowledge, the information in section I, II, III, and IV are accurate and complete. I request a physician to examine applicant, to give needed immunization, and to furnish requested information to other agencies as needed. I give my permission for full participation in GSLC programs, subject to limitation noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as judgement of medical personnel dictates.

Parent/Guardian Signature _____

(Must sign if applicant is under 18 years of age)

Applicants Signature _____

Date Signed _____

Use digital signature option only if you plan to submit form via e-mail via the SUBMIT feature.

SUBMIT