



# PARTICIPANT HEALTH FORM

Name: \_\_\_\_\_  
Last First Middle

Permanent Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Social Security # \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Eve. Phone \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Eve. Phone \_\_\_\_\_

If my parent is not available in an emergency, notify:

\_\_\_\_\_ Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_

\_\_\_\_\_ Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_

## Health History (Check - giving approximate dates)

### Diseases/Illnesses:

Asthma \_\_\_\_\_ German Measles \_\_\_\_\_ Mono \_\_\_\_\_ Bleeding Disorder \_\_\_\_\_  
Heart Problems \_\_\_\_\_ Mumps \_\_\_\_\_ Cancer \_\_\_\_\_ High Blood Pressure \_\_\_\_\_  
Recurring Strep Infection \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Hypoglycemia \_\_\_\_\_  
Respiratory Problems \_\_\_\_\_ Diabetes \_\_\_\_\_ Kidney Problems \_\_\_\_\_  
Swine Flu \_\_\_\_\_ Ear Infections \_\_\_\_\_ Knee Problems \_\_\_\_\_  
Eating Disorders \_\_\_\_\_ Measles \_\_\_\_\_ Surgeries \_\_\_\_\_ HIV Positive/AIDS \_\_\_\_\_  
Other \_\_\_\_\_

Have you been out of the USA in the past 9 months? \_\_\_\_\_ If so, where? \_\_\_\_\_

Current Medications and Dosages: \_\_\_\_\_

Have you been (in the past 12 months) or are you currently being treated for a psychiatric/psychological disorder?

\_\_\_\_\_ If yes, please explain: \_\_\_\_\_

List any previous surgeries or injuries (Give Dates): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has a physician set forth any physical or medical restrictions for you? If so, list them \_\_\_\_\_

\_\_\_\_\_

Do you have any physical or mental restrictions or limitations? If so, list them. \_\_\_\_\_

\_\_\_\_\_

Any illness occurring within the last 5 years that caused you to miss school or work for more than 3 days:

\_\_\_\_\_

**Allergies: (Check- Provide details, if yes)**

Drug Allergies \_\_\_\_\_

Hay Fever \_\_\_\_\_

Insect Stings \_\_\_\_\_ Ivy Poisoning \_\_\_\_\_

Other \_\_\_\_\_

**Immunizations:**

Tetanus – Date of Last Tetanus: \_\_\_\_\_ **(Obtain Tetanus if you are not current)**

Meningitis – Date of Last Meningitis: \_\_\_\_\_

**Insurance:**

I am covered under my parents’ Medical Insurance Plan: \_\_\_Yes \_\_\_ No

If so, name of Insurance Company: \_\_\_\_\_

I have Medical Insurance of my own: \_\_\_Yes \_\_\_ No

If so, name of Insurance Company: \_\_\_\_\_

Insurance Policy #: \_\_\_\_\_ Insurance Policy Phone #: \_\_\_\_\_

**Consent for Treatment**

I hereby give permission to the physician selected by American Missionary Fellowship to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for myself.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Required if participant is under 18 years of age.)