

# PERSONAL HEALTH AND MEDICAL RECORD

Height \_\_\_\_\_ Weight \_\_\_\_\_ Eye color \_\_\_\_\_ Hair color \_\_\_\_\_

## IDENTIFICATION

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Name of parent or guardian \_\_\_\_\_ Home phone # \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ Parent's cell phone # \_\_\_\_\_

Parent's work Name & address \_\_\_\_\_ City \_\_\_\_\_ Parent's work phone # \_\_\_\_\_

*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 \_\_\_\_\_

Hospital Preference:     • St. Joseph's Medical Center     • Morris Hospital     • Silver Cross Hospital

Personal health/accident insurance carrier \_\_\_\_\_ Policy No. \_\_\_\_\_

**ALLERGIES:** Food, medicines, insects, plants Yes    No    Explain: \_\_\_\_\_

## GENERAL INFORMATION: Circle all that apply

ADHD (Attention-Deficit Hyperactivity Disorder)    Convulsions/seizures    Hemophilia    Asthma    Diabetes

High blood pressure    Cancer/leukemia    Heart trouble    Kidney disease

Explain: \_\_\_\_\_

List any **medications taken in the last 30 days**, including drug, dosage, route (oral, injection, etc.), and frequency: \_\_\_\_\_

\_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation in water sports, swimming, or playing strenuous physical games: \_\_\_\_\_

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: \_\_\_\_\_

## Immunizations: (Give date of last inoculation.)

Tetanus toxoid \_\_\_\_\_ Measles \_\_\_\_\_ Polio \_\_\_\_\_

OR DPT \_\_\_\_\_ OR MMR \_\_\_\_\_

Hepatitis A \_\_\_\_\_ Varicella \_\_\_\_\_ OR Chicken pox \_\_\_\_\_

Hepatitis B \_\_\_\_\_

I give permission for full participation in Waterskiing and Wakeboarding Club programs, subject to limitations noted herein.

**In case of emergency**, I understand every effort will be made to contact me (or above named emergency contacts). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date \_\_\_\_\_ Signature of parent/guardian or adult \_\_\_\_\_

Date updated \_\_\_\_\_ Signature of parent/guardian or adult \_\_\_\_\_

Date updated \_\_\_\_\_ Signature of parent/guardian or adult \_\_\_\_\_