Health Form
(Adult)

______________________ ______________________
County Discipline

______________________ ______________________
Name Birth Date

____
Street Address City State ZIP code

(   ) ______________________
Home Phone Number

Physical Record of Participant	Yes	No
Heart Condition	___	___
Diabetes	___	___
Respiratory Problems	___	___
Seizure Disorder	___	___
Allergy to any medications	___	___

List medicines allergic to: ______________________

Other allergies (i.e., food, dust, pollen, animals)

List other allergies ______________________

Date of most recent tetanus shot: ______________________

Any other medical record information that would be beneficial during the program or in an emergency:

____

List any activities the participant should avoid (i.e., swimming):

____

In the event of any emergency, I understand that first aid will be administered. I further understand that in case of serious injury or illness, I hereby give permission to the physician selected to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery.

Yes ________ No ________ ______________________

Signature Date

Person to contact in case of emergency:

______________________ ______________________
Name Home and /or office phone

____
Address

______________________ ______________________
Name Home and/or office phone

____
Address

H/E 9/2003