MEDICAL FORM

General Information

Name (first) ____________________ (middle)_____________ (last)________________________________

Permanent Address_____________________________ Home Phone ( ) _____ - ______________

City__________________ State_____ Zip_________ Work Phone ( ) _____ - ______________

2. School Name/Address____

City__________________ State_____ Zip_________ School Phone ( ) _____ - _______________

3. ___Male ___Female Birth date ___ / ___ / ______ Age_______ Height_______ Weight_______

4. Social Security Number _____ - ____ - _____ 5. Passport #: ___________________________

If not a USA citizen, please give your nationality, visa classification and number:_________________________

6. Marital Status ___Single ___Married ___Separated ___Divorced ___Remarried

Wife: ________________ Children/Ages: ____

IN CASE OF EMERGENCY:

7. Father/Guardian's name/address____________________ Home Phone ( ) ______ - __________________

Employed by: ____________________________ Work Phone ( ) ______ - __________________

Mother/Guardian's name/address___________________ Home Phone ( ) ______ - __________________

Employed by: ____________________________ Work Phone ( ) ______ - __________________

If parents are divorced or separated, who has legal custody? ____Father ___ Mother ___ Joint ___Other _________

Other nearest relative at home Name ______________________ Home Phone ( ) _______ - ___________________

Relationship: ____________________________________

Name of Personal/Family Physician: _______________________ Work Phone ( ) _______ - ___________________

Address: ____

Personal Insurance

1. Health Insurance Co. ____________________________ Policy #______________________________

2. Individual or Group Coverage? ______________________ Policy Holder Name: _______________________

Personal Health

All of the following questions must be answered. Any misrepresentation will void your acceptance.

A. Family Medical History

1. Do your grandparents, parents or siblings have:

Diabetes Yes____ No____ Hypertension Yes____ No____ Heart disease Yes____ No____

Depression Yes____ No____ Mental Illness Yes____ No____

2. If you answered yes to any of the above, explain who and give a brief explanation: ________________________

____

B. Personal Medical History

1. Rate your general health: ___Excellent ___Good ___Fair ___Poor.

2. What was the date and who was the attending physician of your last physical exam? _______________________

____

3. Have you ever had ( )Diabetes ( )Seizures ( )Fainting spells ( )Eating disorders ( )Psychiatric care ( )Respiratory problems ( )Phobias: Explain: ____

4. Have you ever received treatment or counseling for alcohol or chemical abuse? Yes____ No ____

If yes, please specify when and where: ____

____

5. List all surgical operations or hospitalizations you have undergone: *(date, reason for operation or illness, name and address of hospital, name of physician, any remaining effects)* If you have been hospitalized more than two times, please give an explanation: ____

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6. Have you ever been treated by a doctor for any of the following? *(Every item must be checked. If you check "YES" to any of the following, please write a short explanation at the bottom of the page.*

YES	NO	
____	____	Asthma or chronic wheezing
____	____	Emphysema or other lung and/or respiratory problems
____	____	Chronic persistent cough or shortness of breath
____	____	Tuberculosis
____	____	Any skin disorder or disease other than acne
____	____	Chronic or recurrent ear or eye problems
____	____	Impairment of hearing or vision. Meniere's disease, cataracts or glaucoma
____	____	Persistent recurring indigestions, stomach or duodenal ulcers
____	____	Gall bladder stones or colic
____	____	Jaundice cirrhosis or other liver problems
____	____	Intestinal or bowel problems, colitis, diverticulitis, hemorrhoids, other rectal problems or bleeding.
____	____	Any test results indicating exposure to the AIDS virus.
____	____	Albunim, blood or pus in the urine, painful or frequent urination: or kidney problems
____	____	Diabetes or Hypoglycemia (low blood sugar)
____	____	Serious bodily injury
____	____	Mental health counseling or psychiatric treatment
____	____	Rheumatism, gout, arthritis or other forms of swollen painful joints
____	____	Chronic back pain, back injury or surgery, sciatica, scoliosis or other bone or joint disorder
____	____	Cysts, tumors or growths of any kind, hernia or rupture
____	____	Cancer (Type: _________________________)
____	____	Fainting spells, dizziness, convulsions, epilepsy or seizure disorder
____	____	High blood pressure heart murmurs or other cardiac problems
____	____	Vein or circulatory trouble
____	____	Severe migraine headaches
____	____	Goiter, thyroid ailment, high or low metabolism
____	____	Anemia or other blood disorder
____	____	Abnormality of reproductive systems, prostate problems, breast disorder, menstrual disorders, or venereal disease
____	____	Parkinson's disease
____	____	Severe knee injury or problems
____	____	Severe allergic reaction to either food, medicines, bee stings or any other insect bite of sting
____	____	Any other diseases, deformity, or disability not listed above

C. Current Physician's Care or Medications

1. Are you currently taking any prescribed medication? Yes ____ No ____
If yes, please specify the medication and the dosage____
____
2. Are your currently regularly using any non-prescription drugs (antihistamines, sleeping aids,etc.)? Yes ____ No ____
If yes, please specify: ____
3. Are you currently under a physician's care for any illness? Yes ____ No ____
If yes, please explain: ____

I ________________________________ hereby authorize the Project Leader to consent to and authorize for me/us the administration of any and all reasonable first-aid operations, hospitalizations, which in either of their opinions become necessary to save or maintain my life, health, or well-being. I agree to and shall hold harmless from any liability the sponsor for any such determination and authorization given by either or all of them in good after full disclosure by trained medical personnel. In the event of the inability or refusal of the sponsors to give any such consent or authorization, I hereby authorize any paramedic, medical technician, doctor or nurse to take any reasonable action and to administer any reasonable medication which in their professional opinion is necessary to save or maintain my life, health, or well-being.

____
Applicant's Signature

Comments on 6 above:____
____
____
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(please use another sheet if necessary)