Health History Form

TVTD

Weekend Attending: _____

The information on this form is gathered to assist us in identifying appropriate care.

Name: _____
(last) (first) (mi)

Address: _____
(street) (city) (state) (zip)

Date of Birth: _____ Age: _____

In case of an emergency contact:

Name: _____ Relationship: _____

Address: _____
(street) (city) (state) (zip)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Insurance Information:
Is the participant covered by medical/hospital insurance? YES _____ NO _____

If yes, Insurance Name: _____

Permission to provide emergency treatment or necessary care:

I hereby give permission to the medical personnel selected by the camp staff to order X-Rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me. I further, hereby give permission to the physician selected by the camp staff to secure and administer treatment, including hospitalization, anesthesia, surgery, or any other medical decision.

Signature: _____

Printed Name: _____

Date: _____

HEALTH HISTORY

Food, Other Allergies	Describe reaction and management of reaction
_____	_____
_____	_____
_____	_____
_____	_____