

INDIVIDUAL HEALTH FORM

(*All information will be kept private and confidential unless needed for medical purposes*)

Date: _____

Group Name: _____

Applicant Name: _____

DOB: _____ Age: _____ SSN: _____

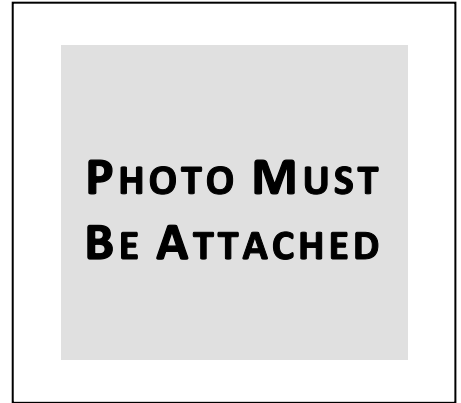
Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell: _____

Gender: Male Female Email Address: _____

Parent/Guardian: _____



Insurance Information

Is the applicant covered by family medical/hospital insurance? Yes No

Name of policyholder: _____ Relationship: _____

Insurance Company: _____ Policy Number: _____

Claim Address: _____

Please attach a front & back copy of your insurance card

Emergency Contact Information

Name: _____ Relationship to Applicant: _____

Phone Number: _____ Alternate Phone Number: _____

Name: _____ Relationship to Applicant: _____

Phone Number: _____ Alternate Phone Number: _____

Name: _____ Relationship to Applicant: _____

Phone Number: _____ Alternate Phone Number: _____

Health History

Please indicate if there's a history of the following conditions
 by circling "Y" or "N" and provide date if applicable

<u>Condition:</u>	<u>Date</u>	<u>Condition:</u>	<u>Date</u>
Ear Infection	Y N _____	Behavioral Problems	Y N _____
Rheumatic Fever	Y N _____	Emotional Problems	Y N _____
Convulsions	Y N _____	Eating Disorders	Y N _____
Diabetes	Y N _____	Severe Reaction To:	
Broken Bones	Y N _____	Poison Ivy, etc.	Y N _____
Hay Fever	Y N _____	Insect Stings	Y N _____
Asthma	Y N _____	Penicillin	Y N _____
Chronic Illness	Y N _____	Other _____	Y N _____
Hospitalization	Y N _____	Pain During Exercise	Y N _____
Surgeries	Y N _____	Seizures	Y N _____
Head Injuries	Y N _____	High Blood Pressure	Y N _____
Unconsciousness	Y N _____	Heart Murmur	Y N _____
Headaches	Y N _____	Back Problems	Y N _____
Sleepwalking	Y N _____	Skin Problems	Y N _____
Glasses, Contacts	Y N _____	Joint Problems _____	Y N _____

Please elaborate on all "Yes" responses above: _____

Health History (cont.)

Allergies – *List all known medical and food allergies that cause severe or fatal reactions:*

Medications – *List ALL medications (including over-the-counter & non-prescription drugs) taken routinely:*

Special Diet – *Inform of us any special dietary needs you may have (doctor prescribed, vegetarian, gluten intolerant, etc.)* _____

Communicable Diseases – *Has the applicant had...*

Chicken Pox	Y	N	_____
Measles	Y	N	_____
German Measles	Y	N	_____
Mumps	Y	N	_____
Other: _____	Y	N	_____

****Results of most recent TB test****

Date Given: _____

Results: _____

Authorization for medical treatment: (must be filled out by parent/guardian if applicant under 18)

This health history is correct and complete as far as I know. I agree to the release of any medical records necessary for insurance purposes. I give permission to New York GO and its representatives to arrange necessary transportation for the above named applicant.

In the event that I cannot be reached in an emergency, this signature is my authorization for emergency treatment and I hereby give permission to the physician selected by the program director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for the person named above.

Signature: _____ Date: _____

****Remember to attach photo and copy insurance card and return this form to your group leader as soon as possible****