

PART TWO: HEALTH HISTORY QUESTIONNAIRE

Full Participant Name:		Zone C Meet	
Full Home Address:		Home Telephone Number:	Date of Birth: ____/____/____ Sex: M F
Parent/Guardian Name:		Relationship:	Height: Weight:
Address (if different than above)		Home Telephone Number:(if different than above)	Does participant have allergic reactions to: <input type="checkbox"/> Yes <input type="checkbox"/> NoPenicillin <input type="checkbox"/> Yes <input type="checkbox"/> NoOther Antibiotics _____ <input type="checkbox"/> Yes <input type="checkbox"/> NoOther Medicine (type) _____ <input type="checkbox"/> Yes <input type="checkbox"/> NoInsect Bites/Stings _____
		Parent/Guardian Work Telephone:	
Alternate contact in the event that the Parent/Guardian cannot be contacted during an injury or illness. (Name, Relationship, Address, and Telephone Number)		Does participant take medication on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Identify _____ (consent for medication administration must be signed on reverse.)	
Physician: _____ Telephone: _____ Insurance Co.: _____ Policy No.: _____		Has participant had or presently experiencing: <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Colitis <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures/Blackouts <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Injury/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Menstrual Difficulties <input type="checkbox"/> Yes <input type="checkbox"/> No Mental/Emotional Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Neck/Back Pain/Injury <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer Other: _____	
Immunization Record			
* MMR (measles, mumps, rubella)			
Dose 1-Immunization at age 1		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dose 2		<input type="checkbox"/> Yes <input type="checkbox"/> No	
* Tetanus-Diphtheria		<input type="checkbox"/> Yes <input type="checkbox"/> No	
* Year of last tetanus boost (must be within last 10 years)			
Has participant ever had major surgery or been hospitalized?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please explain any significant operations, accidents or illnesses, and last medical attention and reason:			
Does the participant have any physical condition(s) requiring special considerations? Explain.			
A physical examination within 24 months of the camp/event is recommended. Date of participant's last physical examination: _____			