



Hugh O'Brian Youth Leadership Record of Medical History

PLEASE TYPE OR PRINT LEGIBLY

Dear Participant:

For our records, and for your protection, please complete this form in it's entirety. Please provide ALL requested information and obtain the signature of your parent or legal guardian.

PERSONAL INFORMATION

(Last Name)

(First Name)

(Middle Initial)

Gender

Date of Birth

Place of Birth

Area Code

Telephone Number

High School / Institution You Represent

Permanent Street Address

City

State

Zip Code

EMERGENCY CONTACT INFORMATION

(Last Name)

(First Name)

Relationship to Student / Participant

Area Code

Primary Phone Number

Area Code

Secondary Phone Number

Name of Family Physician

Area Code

Physician Phone Number

PERSONAL MEDICAL HISTORY

Please check the following diseases you had in the past:

- | | | |
|----------------------------------------------|-----------------------------------------|------------------------------------------|
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> German Measles | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsilitis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | |

OTHER: _____

Please check the following conditions you have or had in the past:

- | | | | | | |
|---------------|--------------------------|---------------|--------------------------|---------------------|--------------------------|
| Asthma | <input type="checkbox"/> | Nose Bleed | <input type="checkbox"/> | Dizzy Spells | <input type="checkbox"/> |
| Ear Infection | <input type="checkbox"/> | Hearing Loss | <input type="checkbox"/> | Fainting Spells | <input type="checkbox"/> |
| Hay Fever | <input type="checkbox"/> | Vision Loss | <input type="checkbox"/> | Difficulty Sleeping | <input type="checkbox"/> |
| Headache | <input type="checkbox"/> | Upset stomach | <input type="checkbox"/> | | |
| Migraine | <input type="checkbox"/> | Convulsions | <input type="checkbox"/> | | |

OTHER: _____

What treatments or medications (if any) do you require for any of the above conditions?

Name of Participant: _____

Are there any past hospitalizations or illnesses we should be aware of?

Please list all allergies (insect stings, plants, foods, medicine, etc)

MEDICATION

Please list any medications you have allergic reactions to (penicillin,sulfa drugs, tetnus antioxin, etc):

Please list the name of any medication you are taking, the dosage, and the condition that requires you to take the medication:

Please list any dietary considerations you have:

IMMUNIZATIONS

Please list the type of illness you have received immunizations for:

Type of Illness	Approximate Date of Immunization
_____ Mumps	_____
_____ Regular Rubeola Measles	_____
_____ Whooping Cough	_____
_____ Influenza/Colds	_____
_____ Typhoid	_____
_____ Diphtheria	_____
_____ Smallpox	_____
_____ Tetanus	_____
_____ Polio Series	_____
_____ Pneumonia	_____

GENERAL

If there are any limitations on the amount of physical exercise you can engage in, please describe and explain: (use additional sheet of paper if necessary)

Signature of Participant _____

Signature of Parent or Legal Guardian _____

Date: _____