Hugh O'Brian Youth Leadership
Record of Medical History

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)

Male Female

Date of Birth

Place of Birth

Area Code Telephone Number

High School / Institution You Represent

Your Permanent Street Address

City State Zip Code

EMERGENCY CONTACT INFORMATION

(Last Name) **(First Name)**

Relationship to Student /Participant

(Area Code) Primary Telephone Number

(Area Code) Secondary Telephone Number

Name of Family Physician

(Area Code) Physician Telephone Number

PERSONAL MEDICAL HISTORY

Please check the following diseases you have had:

- ❑ Bleeding Tendencies
- ❑ Chicken Pox
- ❑ Diphtheria
- ❑ Diabetes
- ❑ Epilepsy
- ❑ German Measles
- ❑ Heart Disease
- ❑ Measles
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Polio
- ❑ Pneumonia
- ❑ Rheumatic Fever
- ❑ Tonsilitis

Check the following Conditions you have had or are subject to now:

Asthma	☐	Asthma	☐	Nose Bleed	☐
Ear Infection	☐	Ear Infection	☐	Hearing Loss	☐
Hay Fever	☐	Hay Fever	☐		
Headache	☐	Headache	☐		
Difficulty Sleeping	☐	Difficulty Sleeping	☐		

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

_____

Are there any past hospitilizations 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 addional sheet of paper if necessary)

_____

_____ _____

Signature of Participant Signature of Parent or Legal Guardian

Date: _____