HEALTH INFORMATION FORM

All questions contained in this questionnaire are strictly confidential and will become part of your health record. This information will be maintained in a secure location in the Glad Tidings administrative office. This form will be removed from the premises in the event East Central Youth has an off-site activity.

Person Completing Form:	**Relationship to student**	**M F Self Other:**
Student's Name (Last, First, M.I.):	M F	**DOB:** (M/D/Y) _____/_____/_____

Address:	**Phone Number:**
Emergency Contact:	**Relationship to student:**
Home Number: **Cell Number:**	**Address:** **Same as student**
Primary care provider:	**Date of last physical exam:**
Phone Number:	**Address:**
Insurance Company:	**Policy Number:_____** **Group Number:_____**
Phone Number:	**Address:**
Who's name is insurance under?	**Relationship to student:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Are Immunizations up to date? ☐ Yes ☐ No ☐ Not sure

Do you have (or have had) any of the following conditions? Check all that apply.

☐ Asthma ☐ Cystic Fibrosis ☐ Diabetes ☐ Sickle Cell Disease ☐ Heart murmur ☐ High blood pressure ☐ Anemia

☐ Leukemia ☐ Chron's Disease ☐ HIV ☐ Eczema ☐ Arthritis ☐ Seizures ☐ Migraine headaches

☐ Depression ☐ ADD ☐ ADHD ☐ Anxiety disorder ☐ Anorexia ☐ Bulimia

☐ Other:

Surgeries: ☐ **No previous surgeries** ☐ **Yes Please give details**

Year	Reason	Hospital

Hospitalizations: ☐ **No previous hospitalizations** ☐ **Yes Please give details**

Year	Reason	Hospital

Have you ever had a blood transfusion or blood products?	Yes	No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to foods	
Name the food	Reaction You Had
Allergies to medications	
Name of Medication	Reaction You Had

FEMALES ONLY		
Have you started menstruating?	Yes	No
Is menses regular?	Yes	No

CONSENT FOR TREATMENT

I _____ give permission for my child _____ to receive medical treatment for minor injuries. In the event of a serious injury I give permission for my child to receive care. I understand that in the event of a serious injury GTYouth staff will attempt to contact me or my emergency representative listed above before treatment is rendered. I further understand that in the event of a serious injury, life or limb preserving treatment will not be delayed pending telephonic contact. I give permission for my child_____ to be transported to a local treatment facility for care when deemed necessary by GTYouth staff. I also give permission for my child's health information to be shared with medical personnel directly involved in his or her care. I understand that it in some cases it may be necessary for my child's health care provider to be contacted for more detailed information. I give permission for those involved in my child's care to contact my child's health care provider.
I understand that I am responsible for medical costs that may be incurred as a result of my child's care to include transport by EMS.

_____ _____
Signature Date

_____
Relationship to student