

HEALTH FORM
Adult

Name: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Spouse's Phone #: _____ Emergency #: _____

Insurance Company: _____ Policy # _____

Another person to notify in case of emergency: _____

Relationship: _____ Telephone: _____

Physician's Name: _____

Address: _____ City: _____, SC, _____

Telephone #: _____

Health History:

Age: _____ Date of Last Tetanus Immunization: _____

Are you taking medication? Yes: _____ No: _____

If so, list all medication(s):

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Check below any condition staff should be aware of:

Heart condition: _____

Eye/Ear Infection _____

Diabetic _____

Convulsions: _____

Drug Allergy: _____

Headaches: _____

Rheumatic Fever: _____

Other Allergies: _____

Explain items checked below _____

Are there any physical restrictions? _____ If yes, please explain: _____

Dated: _____

Signature