Name ______________ Last, First

P00 # ______________ Team ______

☐ Reviewed

HEALTH FORM

GENERAL INFORMATION

Name:____ Date of Birth:____ / ____ / ______

Address:____

City:______________________________________ State:________ Zip:______________

Emergency Phone Numbers: MANDATORY

Mother's name: ______________________________ Email: ________________________________

Mother: *(hm)* (   ) _____ - _______ *(wk)* (   ) _____ - _______ *(cell)* (   ) _____ - _______

Father's name: ______________________________ Email: ________________________________

Father: *(hm)* (   ) _____ - _______ *(wk)* (   ) _____ - _______ *(cell)* (   ) _____ - _______

Another person if parents cannot be reached: ____

Relationship of that person to participant: ____

Phone: *(hm)* (   ) _____ - _______ *(wk)* (   ) _____ - _______ *(cell)* (   ) _____ - _   ___

Family Doctor: ____ Phone: (   ) _____ - _______

HEALTH HISTORY

To Be Completed By a Parent/Legal Guardian if Participant is Under 18

CIRCLE Yes or No ****Please explain anything circled yes on the lines below.***

1. Chicken Pox	Yes	No	13. Prone to bronchitis	Yes	No	25. Heart Problems	Yes	No
2. Birth Defects	Yes	No	14. Frequent sinus problems	Yes	No	26. Sleep Disorders	Yes	No
3. Diabetes	Yes	No	15. Ear/Hearing Problems	Yes	No	27. Bone/Joint Problems	Yes	No
4. Frequent Headaches	Yes	No	16. Ear Infections	Yes	No	28. Convulsions/Seizures	Yes	No
5. Migraine Headaches	Yes	No	17. Frequent nosebleeds	Yes	No	29. Speech Problems	Yes	No
6. Drug Allergies	Yes	No	18. Constipation	Yes	No	30. Eye/Vision Problems	Yes	No
7. Hay Fever *(Note: Training Camp is in a hay field)*	Yes	No	19. Diarrhea	Yes	No	31. Previous Surgeries *(when and for what?)*	Yes	No
8. Allergies to Insect Bites	Yes	No	20. Bladder Control	Yes	No	32. Previous Hospitalizations Including Psychiatric Care *(when and for what?)*	Yes	No
9. Other Allergies	Yes	No	21. Blood Disorders	Yes	No			
10. Toothaches/Wisdom Teeth problems	Yes	No	22. Infections of any kind	Yes	No	33. Physical Handicaps	Yes	No
11. Frequent colds and flu	Yes	No	23. Ulcers	Yes	No	34. Asthma	Yes	No
12. Frequent sore throat or strep	Yes	No	24. Frequent upset Stomach	Yes	No	35. Other	Yes	No

____

____

36. Family history of drug allergies or severe food allergies______________________________________

37. Have you ever seen a counselor or had psychiatric care? _______ If yes, explain

38. Do you, or have you ever struggled with any of the following? __ Eating disorder __ Depression __ ADD/ADHD __ Learning Disability If yes, explain.

39. Do you wear glasses/contacts? _______ If yes, include your prescription.

40. Do you have any activity restrictions? _______ If yes, what? and why?

41. Do you have any special food requirements or food restrictions? _______ If yes, what?

(over)

Name ____________ Last, First

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41. If you have asthma, when was your last attack? _________ Under what conditions do you have problems with asthma?

    You MUST attach a prescription for any medication needed for your asthma and BRING TWO INHALERS if you use them at all.

42. Are you currently taking a prescription medication? _______ If yes, what? ____________________________________
    And why? ____

43. Have you taken any prescription medication in the last three years? _______ What? ______________________________
    When? __________________ Why? ____

44. Do you have any medication that needs to be refrigerated? _______ If yes, explain.

45. **Girls Only:** How often do you get your period? ____________ Is your flow: ___ light ___ medium ___ heavy
    Do you have cramping? _______ If yes, ___ light ___ medium ___ heavy
    Do you take any medication for this? _______ If yes, what? Are you prone to yeast infections? _______ ***If yes, Please bring one treatment of medication with you.***

46. Is there any other information that we need to know about the participant in regards to health?

NOTE: If you have allergic reaction to insect stings or bites, YOU MUST BRING AN EMERGENCY TREATMENT KIT FOR THE SUMMER.

*** Please contact Royal Servants if there are any significant changes in your medical health.**

MEDICAL PERMISSION & INSURANCE

Required for ALL Participants

PERMISSION

I verify that this form has been truthfully completed to the best of my knowledge and I hereby give my permission to the physician or dentist selected by Royal Servants to hospitalize, secure proper treatment and/or order an injection, anesthesia, or surgery for ____.

(name of participant)

Parent/Legal Guardian Signature: ____________________________________ Date: ____ / ____ / ______

(required if participant is under 18 years old)

Participant Signature: ____ Date: ____ / ____ / ______

Make a photocopy of this form for yourself and send the original to Royal Servants upon completion

**** Royal Servants must have this original, signed form ****

INSURANCE

Medical insurance is required. Please complete medical insurance information below.

***Note*: If you do not have medical insurance at this time you may send the information in separately. The insurance information must be sent in by June 1st and be activate prior to travel to Training Camp.**

Parent/Legal Guardian Signature: ____________________________________ Date: ____ / ____ / ______

(required if participant is under 18 years old)

Participant Signature: ____ Date: ____ / ____ / ______

MEDICAL INSURANCE AND DENTAL INSURANCE INFORMATION

medical insurance is required, *dental insurance is not required*

Medical Insurance Company: ____

Policy #: ____ Co-Pay? _____________

Name of insured: ____________________________________ Birth Date: ____ / ____ / ______

Dental Insurance Company:____

Policy #: ____ Co-Pay? _____________

Name of insured: ____________________________________ Birth Date: ____ / ____ / ______