

# MISSOURI YMCA YOUTH IN GOVERNMENT: 2011-2012 ADULT MEDICAL FORM

<b>ADULT INFORMATION</b>					
First:	MI:	Last:			
DOB: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	School / Delegation:			
<b>EMERGENCY CONTACT INFORMATION</b>					
Name:			Relationship to Me:		
Daytime Phone: ( ) -			Evening Phone: ( ) -		
Name:			Relationship to Me:		
Daytime Phone: ( ) -			Evening Phone: ( ) -		
<b>HEALTH HISTORY</b> <i>(Check if you have had any of the following)</i>					
<b>Illnesses</b>		<b>Allergies</b>		<b>Diseases</b>	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Ivy poisoning	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Measles
<input type="checkbox"/> Heart defect / disease		<input type="checkbox"/> Insect stings	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Mumps	<input type="checkbox"/> Asthma
<input type="checkbox"/> Frequent ear infections		<input type="checkbox"/> Other drugs:		<input type="checkbox"/> German measles	
<input type="checkbox"/> Bleeding / clotting disorder					
List injuries and/or operations and dates (use back of form if necessary):					
List any prescription medications and special dispensing needs (use back of form if necessary):					
<b>DOCTORS &amp; HEALTH INSURANCE</b>					
Physician:			Phone: ( ) -		
Dentist:			Phone: ( ) -		
Do you carry family medical / health insurance?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Carrier:			Policy/Group #:		
<b>AUTHORIZATION</b>					
<p>This health history is correct, so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. I hereby give permission to the physician selected by the acting director to order X-rays, routine tests and treatment for the my health, and in the event I cannot respond in an emergency, I hereby give permission to the physician selected by the acting director to hospitalize, secure proper treatment for, and to order injection and or anesthesia and or surgery for me as named above on this form. I understand that my insurance will cover this expense, or I will assume responsibility.</p>					

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Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date