

MISSOURI YMCA YOUTH IN GOVERNMENT – 2009-2010 ADULT MEDICAL FORM

Adult Information	
First: _____	MI: _____ Last: _____
DOB: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F School / Delegation: _____
Emergency Contact Information	
Name: _____	Relationship to Me: _____
Daytime Phone: () -	Evening Phone: () -
Name: _____	Relationship to Me: _____
Daytime Phone: () -	Evening Phone: () -
Health History <i>(Check if you have had any of the following)</i>	
Illnesses: <input type="checkbox"/> Diabetes <input type="checkbox"/> Convulsions <input type="checkbox"/> Heart defect/disease <input type="checkbox"/> Ear infections <input type="checkbox"/> Bleeding/clotting disorder Allergies: <input type="checkbox"/> Hay fever <input type="checkbox"/> Insect stings <input type="checkbox"/> Ivy poisoning <input type="checkbox"/> Penicillin <input type="checkbox"/> Other drugs: Diseases: <input type="checkbox"/> Asthma <input type="checkbox"/> Chicken pox <input type="checkbox"/> German measles <input type="checkbox"/> Measles <input type="checkbox"/> Mumps	
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): 	
Doctors & Health Insurance	
Physician: _____	Phone: () -
Dentist: _____	Phone: () -
Do you carry family medical / health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Carrier: _____	Policy/Group #: _____
Authorization	
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.	

Signature

_____ / _____ / _____

Date