

Harrodsburg Baptist Church

312 S. Main St
 Harrodsburg, KY 40330
 Church Office (859) 734-2339

2010 Participant Health Form

Please provide copy of Insurance Card and Drug Card (If applicable)

Student Name: Last		First		MI	
Date of Birth	Age	Male <input type="checkbox"/>	Female <input type="checkbox"/>	SS#	
Parents/Guardians: Last		First		MI	
Parents/Guardians: Last		First		MI	
Address				Telephone Numbers	
Address				Home ()	
Address				Work ()	
SS#	DOB			Other ()	
Emergency Contact				Telephone Numbers	
Name				()	
Name				()	
Name of Insurance Company			Policy #		
Contact Person			Telephone ()		
Family Doctor			Doctor Phone # ()		
Family Doctor's Address:					
Special Medical Problems, Conditions, or Restrictions:					
Any Medicines?					
Any Allergies?					
Any past medical issues?					
Are you able to participate in athletic events? If no, explain.					
Date of last tetanus:					

Indicate if you have or have had the following (Include year where applicable.)

<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Chorea	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> HIV Positive
<input type="checkbox"/> Infectious Jaundice/Hepatitis	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Measles	<input type="checkbox"/> Polio Myelitis	<input type="checkbox"/> Mumps
	<input type="checkbox"/> Rubella (German)	<input type="checkbox"/> Tuberculosis or TB Contact

The health and immunization history is correct as far as I know. My son/daughter has permission to engage in all prescribed project activities, except as noted by the examining physician and me.

I hereby give permission to Harrodsburg Baptist Church or an approved representative to seek medical attention for my son/daughter in the event I cannot be reached. I hereby give permission to the physician selected by the project director to hospitalize, secure proper treatment for, and to order injection, anesthesia, and/or surgery for my child as named above. This form may be photocopied for use in other projects.

Signature of Parent or Guardian _____ Date: _____

Sworn and subscribed before me on this _____ Day of _____, 20___. (Seal)

Notary Public _____