

Harrodsburg Baptist Church

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

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"/> |
| Parents/Guardians: Last | | First | MI |
| Parents/Guardians: Last | | First | MI |
| Address | | Telephone Numbers | |
| SS# | | DOB | |
| 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 _____