



# ADULT HEALTH HISTORY

Name \_\_\_\_\_ Home Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## EMERGENCY CONTACT:

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Date of last health exam \_\_\_\_\_

Please specify any medical problems noted: \_\_\_\_\_

Are you under care for a medical condition? Please specify: \_\_\_\_\_

Do you take medication on a regular basis? Please specify: \_\_\_\_\_

If you have any ALLERGIES, please indicate source and treatment needed \_\_\_\_\_

Any other health conditions? \_\_\_\_\_

Date of last tetanus immunization (should be within 7 years) \_\_\_\_\_

## PERMISSION TO TREAT

In case of emergency, and the designated emergency contact listed above is not available, the following person is authorized to act in my behalf.

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Relationship \_\_\_\_\_

If neither person is available, the first aider or another adult in the group has my authorization to act on my behalf.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_