



ER Ministries – We Repair Homes – God Repairs Lives

Participant Health Form

Name: _____
Last First Middle

Permanent Address: _____

Home Phone: _____

Parent/Guardian: _____ Daytime Phone: _____

Evening Phone: _____ Cell Phone: _____

Parent/Guardian: _____ Daytime Phone: _____

Evening Phone: _____ Cell Phone: _____

If my parent is not available in an emergency, notify:

_____ Phone: _____ Phone: _____

_____ Phone: _____ Phone: _____

Health History: (Check – giving approximate dates)

Diseases/Illnesses:

- | | |
|--|---|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hypoglycemia _____ |
| <input type="checkbox"/> Bleeding Disorder _____ | <input type="checkbox"/> Kidney Problems _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Knee Problems _____ |
| <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Mono _____ |
| <input type="checkbox"/> Ear Infections _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Eating Disorders _____ | <input type="checkbox"/> Recurring Strep Inf _____ |
| <input type="checkbox"/> German Measles _____ | <input type="checkbox"/> Respiratory Problems _____ |
| <input type="checkbox"/> Heart Problems _____ | |

Allergies:

Drug Allergies: (List any medication you are allergic to)

- | | |
|--|-------|
| <input type="checkbox"/> Hay Fever _____ | _____ |
| <input type="checkbox"/> Insect Stings _____ | _____ |
| <input type="checkbox"/> Ivy Poisoning _____ | _____ |
| <input type="checkbox"/> Other _____ | _____ |

Have you been out of the USA in the past 9 months? _____ If so, where? _____

Immunizations:

Tetanus – Date of Last Tetanus: _____ (Obtain Tetanus if you are not current)

Have you been (in the past 12 months) or are you currently being treated for a psychiatric/psychological disorder? _____ If yes, please explain: _____

List all previous surgeries or injuries (Give Dates): _____

Any illness occurring within the last 5 years that caused you to miss school or work for more than 3 days: _____

I am covered under my parents' Medical Insurance Plan: ____ Yes ____ No

Name of Insurance Company: _____

I have medical insurance of my own: ____ Yes ____ No

Name of Insurance Company: _____

Insurance Policy #: _____ Insurance Policy Phone: _____

Please provide a copy of insurance card

Consent for Treatment

I hereby give permission to the physician selected by the ER Ministry Director/s to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for myself.

(Guardian signature required if under 18 years of age).

Signature: _____ Date: _____