



# Adult Health History Record with Physical

EMPLOYEE: Complete form through Part VII - Consent section on the back.

## PART I: STAFF RECORD

Adult Name - Last, First, Middle Initial \_\_\_\_\_ Birth Date - MM/DD/YYYY \_\_\_\_\_ Age \_\_\_\_\_

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Home Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

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Parent/Guardian Name _____	Day Time Telephone ( ) _____	Evening Phone ( ) _____	Cell Phone ( ) _____
Parent/Guardian Name _____	Day Time Telephone ( ) _____	Evening Phone ( ) _____	Cell Phone ( ) _____

## PART II: EMERGENCY CONTACT IF PARENT/GUARDIAN CANNOT BE REACHED

Name \_\_\_\_\_ Day Time Telephone ( ) \_\_\_\_\_ Evening Phone ( ) \_\_\_\_\_

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Home Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ Relationship to Staff \_\_\_\_\_

## PART III: HEALTH INSURANCE INFORMATION

Name of family PHYSICIAN: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Address of family PHYSICIAN: \_\_\_\_\_ City / State / Zip \_\_\_\_\_

Family Medical/Hospital INSURANCE CARRIER: \_\_\_\_\_ POLICY/GROUP NUMBER: \_\_\_\_\_

Do you have membership with a Health Maintenance Organization (HMO) such as Kaiser, Lifeguard, etc.?  Yes  No

If yes, what ID number do you use? \_\_\_\_\_ What is the HMO main phone number for emergencies? ( ) \_\_\_\_\_

## PART IV: ALLERGIES/ILLNESSES/INJURIES

**Allergic Reaction:** (Check those that apply and specify nature of allergic reaction)  Check here for no known allergies

<input type="checkbox"/> Animals _____	<input type="checkbox"/> Hay Fever _____	<input type="checkbox"/> Medicines/Drugs _____
<input type="checkbox"/> Pollen _____	<input type="checkbox"/> Food _____	<input type="checkbox"/> Insect Stings _____
<input type="checkbox"/> Plants/Poison Oak _____	<input type="checkbox"/> Other (specify) _____	

**Chronic or Recurring Illnesses:** (Check those that apply and give appropriate dates)

<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Heart Defect/Disease _____
<input type="checkbox"/> Musculoskeletal Disorder _____	<input type="checkbox"/> Bleeding/Clotting Disorders _____	<input type="checkbox"/> Ear Infection _____
<input type="checkbox"/> Hypertension _____	<input type="checkbox"/> Seizures/Convulsions _____	<input type="checkbox"/> Mononucleosis _____
<input type="checkbox"/> Skin Disease/MRSA _____	<input type="checkbox"/> Other (specify) _____	

**Childhood Diseases:** (Check those that apply and give appropriate dates)

<input type="checkbox"/> Chicken Pox _____	<input type="checkbox"/> Measles _____	<input type="checkbox"/> German Measles _____
<input type="checkbox"/> Mumps _____	<input type="checkbox"/> Other (specify) _____	

**Other Health Conditions:** (Check those that apply)

<input type="checkbox"/> Attention Deficit Disorder (ADD)	<input type="checkbox"/> Down's Syndrome	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Nose Bleeds
<input type="checkbox"/> Wears Glasses/Contacts	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Emotional Disturbances	<input type="checkbox"/> Menstrual Cramps
<input type="checkbox"/> Sickle Cell Trait/Disease	<input type="checkbox"/> Special Dietary Regimen	<input type="checkbox"/> Dental Braces	<input type="checkbox"/> Fainting
<input type="checkbox"/> Motion Sickness	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Visual Impairment	

List any current physical, mental or psychological health conditions requiring medical treatment, special restrictions or considerations: \_\_\_\_\_

List any dietary restrictions or special considerations: \_\_\_\_\_

List any previous medical treatments, operations or serious injuries, provide dates: \_\_\_\_\_

## PART V: MEDICATION

Over-the-counter medicines will be used to treat routine illness per Treatment Protocols. (Acetaminophen is used in place of aspirin.) Please list any over-the-counter medicines you **DO NOT** want to receive: \_\_\_\_\_

Do you take any medications?  NO  YES  
 If YES, list medication, dosage, and possible side effects.

MEDICATION	DOSAGE	POSSIBLE SIDE EFFECTS
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**NOTE: We cannot administer medication that is not in its original container, labeled by the pharmacy with the name, address, dosage and frequency. Please label with name and dosage any over-the-counter drugs - anti-histamines, vitamins, etc.**

<b>PART VI: IMMUNIZATION HISTORY - REQUIRED</b>			
<b>Vaccines</b>		<b>Year of Basic Immunization</b>	<b>Year of Last Booster</b>
DPT	Diphtheria, Pertussis (Whooping Cough), Tetanus		
TD	Tetanus, Diphtheria		
	Tetanus		
	Oral Polio (Sabin)* TOPV		
	Injectable Polio (Salk)		
	Measles (hard measles, red measles, Rubeola)		
	Rubella (German measles, 3-day measles)		
	Tuberculin test given _____ (most recent)		
	Hepatitis B		
	Other:		

List any condition that would limit full activity and in what way: \_\_\_\_\_

\_\_\_\_\_

Additional comments: \_\_\_\_\_

\_\_\_\_\_

**PART VII: PATIENT CONSENT**

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. I am in good health. I give permission for treatment for routine medical and/or first aid needs, as outlined in the Treatment Protocols and for the administration of prescribed medications. In the event I cannot be reached in an emergency, I give my permission to receive emergency medical and surgical treatment and to be hospitalized, if necessary. It is understood every effort will be made to contact me or the emergency contact noted above, before taking this action.

\*All medications being taken are listed on the front of this form.

\_\_\_\_\_  
 Signature of Adult Staff Member (or parent if Staff is younger than 18 years of age) Date