

Blueprint Ministries

PARTICIPANT HEALTH FORM

Name: _____ Date of Birth _____
Last First Middle

School _____ Grade _____

Permanent Address: _____

Home Phone: _____ Cell Number: _____

Parent: _____ Day Phone: _____ Cell _____

Parent: _____ Day Phone: _____ Cell _____

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

Name: _____ Phone: _____

Name: _____ Phone: _____

Health History: (Check - giving approximate dates)

Diseases/Illnesses:

Asthma _____	German Measles _____	Mono _____
Bleeding Disorder _____	Heart Problems _____	Mumps _____
Cancer _____	High Blood Pressure _____	Recurring Strep Inf. _____
Chicken Pox _____	Hypoglycemia _____	Respiratory Problems _____
Diabetes _____	Kidney Problems _____	Ear Infections _____
Knee Problems _____	Eating Disorders _____	Measles _____

Allergies:

Hay Fever _____
Insect Stings _____
Ivy Poisoning _____
Other _____

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

Other Health Information:

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

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

List any 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

If so, name of Insurance Company: _____

I have Medical Insurance of my own: ___ Yes ___ No

If so, name of Insurance Company: _____

Insurance Policy #: _____ Insurance Policy Phone #: _____

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

Consent for Treatment

I hereby give permission to the physician selected by the Blueprint Ministries Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for myself or child as parent or guardian.

Signature: _____ Date: _____