Blueprint Ministries Participant Health Form

Participant Name: _____ Birth: _____
School: _____ Grade: _____
Address: _____ City: _____ ST: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Parent: _____ Day Phone: _____ Cell: _____
Parent: _____ Day Phone: _____ Cell: _____
If my parent is not available in an emergency, please notify:
Name: _____ Contact: _____
Name: _____ Contact: _____

Health History: Please check applicable items:

_____Bleeding
_____Cancer
_____Chick Pox
_____Diabetes
_____Knee Problems
_____Heart Problems
_____High Blood Pressure
_____Hypoglycemia
_____Kidney Problems
_____Eating Disorders
_____Mono
_____Mumps
_____Recurring Strep
_____Ear Infections
_____Measles
_____Asthma

Allergies: Please check applicable items:

_____Hay Fever
_____Insect Stings
_____Poison Ivy or Oak
_____Other: _____

Drug Allergies:(List any medication you're allergic to)
_____
_____
_____
_____

Other Health Information:

Date of Last Tetanus Shot: _____ (Obtain Tetanus if you are not current)
Have you been (in past 12 months) or are you currently being treat for a psychiatric/psychological disorder? _____ If yes, please explain: _____
List any previous surgeries or injuries with dates: _____
_____
Any illness occurring within the last 5 years that caused you to miss school or work for more than 3 days? _____

Insurance:

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 #: _____ Policy Phone #: _____
If you have been out of the country in the past 9 months, where did you go? _____

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: _____
Printed Name: _____