YOUTH MEDICAL HISTORY

First Presbyterian Church 300 36th Street, Virginia Beach, Virginia 23451
Phone: (757) 428-6332 Fax: (757) 428-6615

Youth Name ______________________ DOB ______________
Address ______________________ Phone # ______________

1st Parent/Guardian ______________ Work Phone # ________ Other Phone # ________
2nd Parent/Guardian ______________ Work Phone # ________ Other Phone # ________

Name of Family Physician ____________ Phone # ____________ FAX # ____________
Health Insurance carrier ______________________ Policy/group # ____________

Part 1: Illnesses and injuries (check those that apply, provide appropriate dates)

Chronic or Recurring Illness

☐ Ear Infection ☐ Bleeding/Clotting Disorders ☐ Hypertension ☐Asthma
☐ Heart Defect/Disease ☐ Musculoskeletal Disorder ☐ Seizures ☐ Diabetes
☐ Other (specify) ______________________________

Date of last health examination ________ Were any medical problems noted in last health exam? ☐ Yes ☐ No
If yes, please specify: ______________________________

Is participant currently under the care of a physician or psychologist? ☐ Yes ☐ No

Since last health exam, has participant had

☐ a serious injury requiring medical attention ☐ an illness lasting more than five (5) days
☐ any prescribed or over-the-counter medication ☐ a surgical operation or fracture
☐ treatment in a hospital or emergency room ☐ any restrictions concerning physical activities
☐ any exposure to a contagious disease

Please explain (and provide dates for) any answers that were marked: ______________

Part 2: Allergies

(if checked, please supply nature of allergy)

☐ Animals ________ ☐ Hay Fever ________
☐ Pollen ________ ☐ Food ________
☐ Medicines ________ ☐ Insects ________
☐ Plants ________ ☐ Other ________

Part 3: Other Health Conditions (check those that apply)

☐ Bed wetting ☐ Emotional disturbances
☐ Constipation ☐ Fainting
☐ Menstrual cramps ☐ Hearing impairment
☐ Motion sickness ☐ Sickle cell trait or disease
☐ Nosebleeds ☐ Special dietary regimen
☐ Sleep disturbances ☐ Wear glasses or contact lenses
☐ Other (specify) ______________________

Part 4: Immunization History

Immunization	Year Primary series completed	Year of Last Booster
Diphtheria, Tetanus, Pertussis (DTP)	________	________
Poliomyelitls	________	________
Haemophilus influenza Type b	________	________
Measles (Rubeola)	________	________
Rubella (German measles)	________	________
Mumps	________	________
Measles, Mumps, Rubella (MMR vaccine)	________	________
Hepatitis B vaccine	________	________
Varicella vaccine	________	________
Other ________________		

Please explain any items that are checked: ______________________________

PARENTS AUTHORIZATION: If my child needs medical treatment, I give my permission for him/her to be attended for care. Furthermore, I hereby give permission for the administration of anesthesia and performance of emergency surgery, if deemed advisable in the opinion of physicians.

DATE ______________ SIGNATURE ______________________________

PARENT, please check carefully, and affirm annually that information above is correct:

Date	Initials	Date	Initials	Date	Initials	Date	Initials	Date	Initials
____	____	____	____	____	____	____	____	____	____