

# HEALTH FORM

## Cumberland Presbyterian Youth Conference

Please provide the information requested below and return your completed form with your registration materials to: CPYC, 8207 Traditional Place, Cordova, TN 38016.

(Please print or type.)

Your Social Security No. \_\_\_\_\_

<i>Last Name</i>	<i>First Name &amp; Middle Initial</i>	<i>Birth Date</i>	<i>Gender</i>
<i>Street or Route</i>	<i>City</i>	<i>State</i>	<i>Zip</i>

*Parent, Guardian, or Spouse (name, address, & telephone no.)*

*If parent, guardian, or spouse is unavailable in an emergency, notify (name, address, & telephone no.):*

*Family Physician (name, address, & telephone no.)*

*Date of most recent physical examination:* \_\_\_\_\_

*Is the above named conferee in general good health and able to participate in normal conference activities?*

*(Check one.)*     **YES**     **NO** *(If NO, please submit a statement indicating limitations.)*

**HEALTH HISTORY:** *Place a check mark in the space beside the item(s) below with which you have problems.*

*Ear Infections*     *Hay Fever*     *Diabetes*     *Fainting*     *Rheumatic Fever*

*Ivy Poisoning*     *Convulsions*     *Asthma*     *Insect Stings*     *Penicillin*

*Other known allergies* \_\_\_\_\_

*If any of the above is checked, please submit a statement of the date of the last occurrence of the problem, and how you were treated including medication. Proper medicine must be brought to CPYC and the director informed about it.*

*Operations or serious injury and date(s)* \_\_\_\_\_

*Give most recent dates of the following immunizations: D.P.T. Series* \_\_\_\_\_ *D.P.T. Booster* \_\_\_\_\_

*Polio Series* \_\_\_\_\_ *Polio Booster* \_\_\_\_\_ *Mumps* \_\_\_\_\_ *Tetanus Booster* \_\_\_\_\_

*List all current medication by name and dosage (including vitamins). Use Back of Form if needed:*

*Family Health Insurance Company (name, address, telephone, and policy number)*

*Your Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

**PARENT OR GUARDIAN:** *In case of medical emergency, I understand the every effort possible will be made to contact parents or guardian of conferee. In the event that I cannot be reached, I hereby give permission to the physician selected by the conference director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my son or daughter, as named herein.*

*Signature of Parent/Guardian* \_\_\_\_\_ *Date* \_\_\_\_\_