Christ Lutheran Church
Health History

The Christ Lutheran Church policy of health and safety implies the right of the organization to be assured, as far as possible, that the participants are physically able to take part in activities.

Date: _____

Name: _____

Address: _____
Street

_____
City State Zip

Date of Birth: _____ Age: _____

PARENT OR GUARDIAN (if member is not an adult):

Name: _____

Phone (home): _____

Business Address: _____
Street

_____
City State Zip

Phone (Business): _____

FAMILY PHYSICIAN:

Name: _____

Phone: _____

EMERGENCY CONTACT (in case parent cannot be reached):

Name: _____ Relationship: _____

Address: _____ Phone: _____

INSURANCE

Carrier: _____
Family Medical/Hospital Insurance

Policy or Group Number: _____

LAST HEALTH EXAM

Date: _____

Were there any complicating medical problems at that time? _____

Specify: _____

Since the last health examination, has the person had:

	(Yes)	(No)
• A serious injury requiring medical attention?	☐	☐
• An illness lasting more than five days?	☐	☐
• A surgical operation or fracture?	☐	☐
• Any prescribed or over-the-counter medication?	☐	☐
• Treatment in a hospital emergency room?	☐	☐
• Any restrictions concerning physical activities?	☐	☐

Please explain "yes" to above: _____

Is person currently under the care of a physician or psychologist? _____

Specify: _____

PART I Illness & Injuries (Check those that apply)

☐ Asthma ☐ Seizures ☐ Heart Disease/Defect
☐ Diabetes ☐ Hypertension ☐ Bleeding/Clotting Disorder
☐ Ear Infection ☐ Musculoskeletal Disorders
☐ Other: _____

PART II Allergies (Check those that apply and specify nature)

Animals: ☐ _____
Food: ☐ _____
Insect Sting: ☐ _____
Medicine/Drugs: ☐ _____
Plants: ☐ _____
Pollen: ☐ _____
Hay Fever: ☐ _____
Other: ☐ _____
Treatment Used: _____

PART III Immunization Year

Tuberculin Test (year): _____ Results: _____

	Primary Series (Year)	Booster (Year)
D.P.T.		
Td		
Measles		
Mumps		
Polio		
Rubella		
Hib		
Other:		

PART IV Other Health Conditions (Check those that apply)

☐ Bed Wetting ☐ Nosebleeds
☐ Constipation ☐ Sickle Cell Disease
☐ Emotional Disturbances ☐ Special Diet
☐ Fainting ☐ Contact Lenses
☐ Hearing Impairment ☐ Glasses
☐ Menstrual Cramps ☐ Sleep Disturbances
☐ Motion Sickness
☐ Other: _____

Indicate any information that would be useful to the adult in charge regarding the above conditions. Also indicate any activities to be encouraged or restricted.

_____

_____

_____

_____

I know of no reason(s), other than the information indicated on this form, why my child should not participate in prescribed activities except as noted.

Signature of Parent/Legal Guardian: _____ Date: _____