

**Prince of Peace Lutheran Church**

**ADULT LEADER - Health History / Authorization for Emergency Medical Treatment**

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ **M F**

Circle one

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact Information	
Name	
Address (if different than above)	
Daytime phone	
Evening Phone	
Cell Phone	
Alternate contact - name	
Alternate phone	

**Health History**

Illness/Injury	Check any that apply	Allergies	Check any that apply	Other Health Conditions	Check any that apply
Asthma		Animals		Motion Sickness	
Diabetes		Hay Fever		Hearing Impaired	
Epilepsy		Medicines/drugs		Fainting	
Kidney Disease		Food		Emotional Disturbances	
Convulsions		Insect Stings		Constipation	
Ear Infections		Plants		Nose Bleeds	
Heart Disease		Other		Special Dietary Needs	
Other				Physical Impairments	
				Other	

Specific information regarding any item checked above (continue on back if needed):

\_\_\_\_\_

**Health Information**

Date of last health examination \_\_\_\_\_ Date of last tetanus shot \_\_\_\_\_

Medications being taken currently (include dosage) \_\_\_\_\_

Answer Yes or No to the following questions:

Were any complicating medical problems noted in your last health examination? \_\_\_ Are you currently under a physicians care for a medical problem? \_\_\_ Since your last health exam, have you had: a serious injury requiring medical attention? \_\_\_ an illness lasting longer than one week? \_\_\_ a surgical operation or fracture? \_\_\_ treatment in a hospital as an inpatient or in the emergency room? \_\_\_

Please explain any "Yes" answer and include dates (continue on back if needed) \_\_\_\_\_

\_\_\_\_\_

Any other pertinent facts to which a medical doctor should be alerted or that would be useful to a person in charge \_\_\_\_\_

\_\_\_\_\_

*I consent to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency. I understand that reasonable efforts will be made to contact my designated emergency contact listed above or my designated alternate. If it is believed that my life or health may be adversely affected by the delay that an attempt to contact my designated emergency contact listed above or my designated alternate would cause, I consent to: 1.) the administration of medical treatment and/or surgical procedures deemed necessary by the medical doctor and/or medical facility or chosen person in charge; and 2.) the immediate administration of life-sustaining measures deemed necessary under the circumstances. I agree to assume liability for any medical expenses involved.*

\_\_\_\_\_  
Signature Adult Participant

\_\_\_\_\_  
Date