

**Project Venture – Youth Medical History Form**

**INSTRUCTIONS:** Complete all parts of this form, front and back. Parent's signature is required if participant is under 18 years old.

**NOTE:** Full disclosure of your current health is required for participation.

**GENERAL INFORMATION**

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (Box) (City/State) (Postal Code)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Male Female Status Indian Non-Status Indian Other

**EMERGENCY CONTACT INFORMATION (In the event of an emergency, who do we contact):**

Parent's Name: \_\_\_\_\_

Phone (Day): \_\_\_\_\_ (Cell): \_\_\_\_\_

2<sup>nd</sup> contact's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone (Day): \_\_\_\_\_ (Cell): \_\_\_\_\_

**HEALTH HISTORY**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Do you wear glasses?  Yes  No  
Do you wear contacts?  Yes  No

Health Card# \_\_\_\_\_ Family Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_

Are you currently taking medication?  Yes  No  
If yes, please list and explain: \_\_\_\_\_

Do you have asthma?  Yes  No If yes, bring your inhaler along.

Do you have any disabilities?  Yes  No  
If yes, please explain: \_\_\_\_\_

Do you have any recent injuries, illnesses or operations?  Yes  No  
If yes, please explain: \_\_\_\_\_

Continue on Back

Do you have diabetes, seizures or frequent fainting/dizziness?  Yes  No  
If yes, please explain: \_\_\_\_\_

Do you have any back, neck or spine injury/pain?  Yes  No  
If yes, please explain: \_\_\_\_\_

Do you have migraines or suffer from headaches?  Yes  No  
If yes, please explain: \_\_\_\_\_

Do you have a history of heart problems?  Yes  No  
If yes, please explain: \_\_\_\_\_

Are you pregnant?  Yes  No  
If yes, you cannot actively participate without written permission from your physician.

Individuals suffering from Musco-skeletal injuries or cardiovascular illness will not be permitted to participate in certain activities without written permission from their physician.

Please state the type of physical condition you are in:  Athletic  Good  Fair  Poor

**ALLERGIES: (please check all that apply. Bring your epi-pen or other medications along.)**

Poison Ivy  Bee stings  other insect stings/bites  Penicillin  Aspirin

Foods (please list) \_\_\_\_\_

Other (please explain) \_\_\_\_\_

Please list. Include allergies to medication: \_\_\_\_\_

Participants Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_  
(if under 18 years old)

Date: \_\_\_\_\_

If you have any questions feel free to contact Dolores Winn @ 989-775-4920