ER Ministries – We Repair Homes – God Repairs Lives

Participant Health Form

Name: ____
Last First Middle

Permanent Address ____
____

Home Phone: ________________

Parent/Guardian: ___________________ Daytime Phone: ______________________
Evening Phone: ___________________ Cell Phone: ______________________
Parent/Guardian: ___________________ Daytime Phone: ______________________
Evening Phone: ___________________ Cell Phone: ______________________

If my parent is not available in an emergency, notify:
____________________________ Phone: _______________ Phone: ___________
____________________________ Phone: _______________ Phone: ___________

Health History: (Check – giving approximate dates)

Diseases/Illnesses:

☐ Asthma	__________	☐ Hypoglycemia	__________
☐ Bleeding Disorder	__________	☐ Kidney Problems	__________
☐ Cancer	__________	☐ Knee Problems	__________
☐ Chicken Pox	__________	☐ Measles	__________
☐ Diabetes	__________	☐ Mono	__________
☐ Ear Infections	__________	☐ Mumps	__________
☐ Eating Disorders	__________	☐ Recurring Strep Inf	__________
☐ German Measles	__________	☐ Respiratory Problems	__________
☐ Heart Problems	__________		

Allergies:		**Drug Allergies: (List any medication you are allergic to)**
☐ Hay Fever	__________	___________________________________
☐ Insect Stings	__________	___________________________________
☐ Ivy Poisoning	__________	___________________________________
☐ Other	__________	___________________________________

Have you been out of the USA in the past 9 months? _________ If so, where? ________________

Immunizations:

☐ Tetanus – Date of Last Tetanus: ______________ (Obtain Tetanus if you are not current)

Have you been (in the past 12 months) or are you currently being treated for a psychiatric/psychological disorder? _______________ If yes, please explain: ____________________________________

List all previous surgeries or injuries (Give Dates): ______________________________________
____

Any illness occurring within the last 5 years that caused you to miss school or work for more than 3 days:
____

I am covered under my parents' Medical Insurance Plan: _____ Yes ___ No

Name of Insurance Company: ____

I have medical insurance of my own: ______ Yes ______ No

Name of Insurance Company: ____

Insurance Policy #: _______________________ Insurance Policy Phone: ____________________

****Please Provide a Copy of Your Valid Insurance card****

Consent for Treatment

I hereby give permission to the physician selected by the ER Ministry Director/s to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for myself.
(Guardian signature required if under 18 years of age).

Signature: ______________________________________ Date: ________________________