

YOUTH HEALTH HISTORY

IMPORTANT! Please do not send this youth if he/she has been exposed to any communicable disease two weeks prior to any activity.

Name and phone number of a non-family member in case of an emergency.

HEALTH HISTORY: (Check any problems that may apply.)

- Frequent Colds, Kidney, Frequent Sore Throats, Bed Wetting, Sinusitis, Female Trouble, Convulsions, Abscessed Ears, Bronchitis, Fainting, Sleep Walking, Stomach Upsets, Home Sick, Constipation, Diabetes, Heart Trouble, Dental Trouble, Ivy Poisoning

Please list any other serious condition that the youth workers need to know. We want a safe and healthy activity for your youth and others.

Two blank lines for additional information.

ALLERGIC REACTIONS:

- Bee Sting, Penicillin, Other Drugs, Other Drugs

IMMUNIZATIONS:

- D. P. T. Series, Booster, Tetanus Booster

Medicine the youth will be taking:

COMMENTS: