



Crossroads Connects

Health Form

PERSONAL INFORMATION

Name _____ DOB / / Age ____ Gender: Male / Female
 Social Security Number _____ Parent/Guardian Name If under 18 _____
 Home Phone # _____ Work # _____ Cell # _____
 Home Address _____

INSURANCE DETAILS

Name & Address: _____ Subscriber: _____
 Policy #: _____ Group #: _____ Phone #: _____

EMERGENCY CONTACT

Every effort will be made to contact the parent/guardian (*if under 18*) in the event of an illness or other problem. Please indicate 2 other persons who know you or your child, who have authorization for transportation, and who may be contacted if necessary.

Name _____ Relation _____ Tel # _____ Other # _____
 Name _____ Relation _____ Tel # _____ Other # _____

ALLERGIES

Please list all known allergies. Describe reaction and management of the reaction:

Medication Allergies _____

 Food allergies _____

 Other allergies inc. insect stings, hay fever, asthma, animal dander, etc. _____

MEDICATIONS BEING TAKEN: Please list ALL medications (inc. over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original package/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. (*Attach additional pages if needed for more medications*)

Med # 1 _____ Dosage/Times taken _____ Reason for taking _____
 Med # 2 _____ Dosage/Times taken _____ Reason for taking _____
 Med # 3 _____ Dosage/Times taken _____ Reason for taking _____

GENERAL QUESTIONS (explain yes answers below):

Has/does the participant:	YES	NO	YES	NO
1. Had any recent injury/illness/infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	8. Ever been hospitalized?	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	9. Ever had seizures?	<input type="checkbox"/>
3. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	10. Have diabetes?	<input type="checkbox"/>
4. Have any skin problems (e.g. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have asthma?	<input type="checkbox"/>
5. Had any problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have a history of bed-wetting?	<input type="checkbox"/>
6. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>	13. Ever had emotional difficulties?	<input type="checkbox"/>
7. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>		

Please explain any YES answers, noting the number of the questions:

Sign _____ Date _____
 Parent/Guardian if under 18