NPGC SCTP
Participant Health History Form

This information will be kept confidential. Please print your information clearly in ink.

Name:____ Date of Birth:____ /____ /____ Male / Female

Address:____

Town / City State Zip

Phone Numbers:

Work:___________________________ Home: _______________________________Cell:_______________________

Please provide two emergency contacts:

Name:____ Name:____________________________________

Relationship:____ Relationship:_______________________________

Phone: ____Phone:____________________________________

Name of family doctor:____________________________________ Office number:_______________________________

Name of family dentist: ___________________________________Office number:_______________________________

Are you covered by medical insurance? ☐ Yes ☐ No

Insurance Company: ____Policy #:______________________________

Please list all known allergies and your reactions to them:

____

____

Please list all medications being taken routinely:

____

____

Have you had the following (please circle one answer for each question)?

Any recent injury or illness	Yes	No	Help for emotional problems	Yes	No
A chronic illness/condition	Yes	No	Have asthma/allergies	Yes	No
Ever been hospitalized/surgery	Yes	No	Pain in your joints	Yes	No
Had a head injury/unconscious	Yes	No	Ever had a seizure	Yes	No
Problems with sleep walking	Yes	No	Wear glasses/contacts	Yes	No

Details:

Which of the following have you had (please circle all that apply):

Measles Mumps Chicken Pox German Measles Hepatitis A Hepatitis B Hepatitis C

Is there anything else we should know in case of a health-related emergency?

____

I verify that the above medical information is complete and accurate. I hereby give permission to NPGC SCTP coaches and staff to seek emergency treatment if I cannot do so myself. In the event the emergency contacts cannot be reached, I give permission to the physician/hospital selected by NPGC SCTP coaches and staff to secure and administer treatment for myself, including hospitalization.

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Participant Signature Date

____

Parent / Guardian Signature Date