

MEDICAL QUESTIONNAIRE

(To be filled out by parent or guardian, if applicant is under 18)



CEF

CHILD EVANGELISM
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Name of Applicant: _____ Age: _____

MEDICAL COVERAGE FOR APPLICANT:

Name of Insurance Company: _____ Policy #: _____

Address of Company: _____

MEDICAL HISTORY

| | Is the applicant subject to: | | Has applicant had: | |
|---------------------------------|------------------------------|----|----------------------------------|----|
| | Yes | No | Yes | No |
| Asthma | | | Chicken Pox | |
| Hayfever | | | Rheumatic Fever | |
| Epilepsy | | | Mumps | |
| Food Allergies | | | Measles | |
| (list) | | | Rubella (German Measles) | |
| Allergies to Medications | | | | |
| (list) | | | Serious reaction to bee sting | |
| Other Allergies | | | Other? | |
| (Flowers, Grasses, etc.) (list) | | | (list) | |
| | | | | |

Does the applicant have: (circle answer)

Diabetes..... Yes No

Hypoglycemia..... Yes No

Is the applicant on a special diet..... Yes No

If so what is it? _____

Has the applicant had any illness requiring a visit to the doctor or hospital in the last 3 months? Yes No

If so what was the health problem? _____

Please list any prescription drugs being brought by the applicant:

| Name of Medication | What it is for: | Dosage |
|--------------------|-----------------|--------|
| | | |

Please list any non-prescription drugs being brought by the applicant that you give permission for him / her to keep and take at his / her own discretion: _____

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the training staff, to hospitalize and secure proper treatment (including surgery) for my child. I agree to use my own medical insurance in the event of necessary medical treatment.

Signature of Parent / Guardian: _____ Date: _____

Name: _____

Name: _____

Emergency Ph: # 1: _____

Emergency Ph: # 2: _____