

American Patriot Conference Health History Form

(Please Print All Information)

PARTICIPANT INFORMATION:

Name _____ Social Security Number _____
 Last *First* *MI*
 Address _____ Phone () _____
 City _____ E-Mail _____
 State _____ Zip _____ Sex F _____ M _____ Birth Date _____ Age _____

PARENT/GUARDIAN INFORMATION:

Father's Name _____
 Father's Work Phone() _____ E-Mail _____
 Mother's Name _____
 Mother's Work Phone() _____ E-Mail _____
 Who has Primary Custody of the Participant? _____

PHYSICIAN/INSURANCE INFORMATION:

Family Physician Name _____ Phone () _____
 Dentist/Orthodontist Name _____ Phone () _____
 Do YOU Carry Family Medical/Hospitalization Insurance? Yes _____ No _____
 Carrier Name _____ Policy Number _____

PARENT/GUARDIAN EMERGENCY CONTACT INFORMATION

Where can YOU be reached in the event on an emergency?
 Location _____ Phone () _____
 If YOU cannot be reached who should we notify?
 Name _____ Phone() _____
 Relationship _____ E-Mail _____
 Address _____ City _____ State _____ Zip _____
 Work Address _____ Phone () _____
 City _____ State _____ Zip _____

IMMUNIZATION HISTORY: (Please indicate date of vaccination and/or disease)

Immunization	Yes/No	Date
Tetanus	_____	_____
Diphtheria	_____	_____
Polio	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Pertussis	_____	_____
Chicken Pox	_____	_____
Other	_____	_____

Does your child have an Insurance Card with them?

Yes _____ No _____