

# American Patriot Conference Health History Form

PRINT ALL INFORMATION

## PARTICIPANT INFORMATION

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
          Last                      First                      Middle                      (optional, may be needed if hospitalized)

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
City: \_\_\_\_\_ Email: \_\_\_\_\_  
State: \_\_\_\_\_ ZIP: \_\_\_\_\_ SEX: F \_\_\_ M \_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

## PARENT / GUARDIAN INFORMATION

Father's Name (or Guardian): \_\_\_\_\_  
Father's Work Phone: (\_\_\_\_) \_\_\_\_\_ Work Email: \_\_\_\_\_

Mother's Name (or Guardian): \_\_\_\_\_  
Mother's Work Phone: (\_\_\_\_) \_\_\_\_\_ Work Email: \_\_\_\_\_

Who has primary custody of the participant? \_\_\_\_\_

## PHYSICIAN / INSURANCE INFORMATION

Family Physician's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Dentist / Orthodontist Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

DO YOU CARRY FAMILY MEDICAL / HOSPITAL INSURANCE? YES \_\_\_ NO \_\_\_  
CARRIER: \_\_\_\_\_ Policy/ Group #: \_\_\_\_\_

## PARENT / GUARDIAN EMERGENCY CONTACT INFORMATION

WHERE CAN YOU BE REACHED IN THE EVENT OF AN EMERGENCY?  
Location: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

IF YOU CANNOT BE REACHED WHO SHOULD BE NOTIFIED?  
Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Home Address: \_\_\_\_\_ Email: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Work Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

IMMUNIZATION HISTORY			indicate the date of vaccination and/or the disease		
Immunizations	Last Year Received		Vaccination	Disease	
Tetanus	_____	_____	_____	_____	_____
Diphtheria	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____
			Measles	_____	_____
			Mumps	_____	_____
			Rubella	_____	_____
			Pertussis	_____	_____
			Chicken Pox	_____	_____