

## Individual Health Information Form for Chaperones

Please give the following health information in order for the Project Leadership to be aware of any risk your participation may create. Project leaders are free to require a doctor's release statement if a serious health if a serious health problem exists. Failure to provide known information will release the team, project leaders, Chapelgate Christian Academy, and Chapelgate Presbyterian Church from responsibility from complications brought on by the activities of this project.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Health Care Provider(s) – Name(s) and Contact Information:

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A. Have you ever been treated or see a physician for any of the following:

**(Circle the number if answer is "yes")**

- |                                    |   |
|------------------------------------|---|
| 1. Heart trouble                   | 29. Sugar, albumin, blood or pus in urine         |
| 2. Heart murmur                    | 30. Psychiatric problem                           |
| 3. Rheumatic fever                 | 31. Emotional problem                             |
| 4. Chest pain                      | 32. Nervous problem                               |
| 5. Stroke                          | 33. Epilepsy                                      |
| 6. High blood pressure             | 34. Convulsion                                    |
| 7. Abnormal pulse                  | 35. Dizziness                                     |
| 8. Hardening of the arteries       | 36. Loss of consciousness                         |
| 9. Diabetes                        | 37. Frequent headaches                            |
| 10. Anemia                         | 38. Other nervous system disorder                 |
| 11. Thyroid or other gland problem | 39. Cancer  |
| 12. Blood disorder                 | 40. Tumor   |
| 13. Asthma                         | 41. Skin disorder                                 |
| 14. Bronchitis                     | 42. Hernia  |
| 15. Tuberculosis                   | 43. Circulatory disorder                          |
| 16. Other lung disorder            | 44. Arthritis                                     |
| 17. Ulcer                          | 45. Sciatica                                      |
| 18. Gall bladder disease           | 46. Gout  |
| 19. Colitis                        | 47. Deformity                                     |
| 20. Internal bleeding              | 48. Amputation                                    |
| 21. Digestive disorder             | 49. Disease of eyes                               |
| 22. Intestinal disorder            | 50. Disease of ears                               |
| 23. Hepatitis                      | 51. Disease of nose                               |
| 24. Cirrhosis                      | 52. Disease of throat                             |
| 25. Other liver trouble            | 53. Tested positive for any kind of blood disease |
| 26. Kidney stone or infection      | 54. Allergy (food, medication or other)           |
| 27. Bladder stone or infection     | 55. Pregnant (currently)                          |
| 28. Prostate trouble               |   |

*Return completed form to team leader.*

B. If “yes” to any of the above, please explain below (include date of last treatment or office visit for each item, labeled by number). Please attach another sheet, if necessary.

C. Date of last tetanus booster \_\_\_\_\_  
(Tetanus vaccination must be dated within the last 10 years)

D. What medication will you be taking during the project (and for what reason/health concern)?  
Please attach another sheet, if necessary.

E. Are there any activities that you believe that your doctor/health care provider would restrict you from doing/participating in? If so, please explain.

\_\_\_\_\_  
Participant Name (Printed)

\_\_\_\_\_  
Participant Signature

Date: \_\_\_\_\_

*Return completed form to team leader.*