

SHORT TERM HEALTH INFORMATION

RCF 01-01A SEPT 05

Directions: Use with volunteers and members for activities 24 hours to 48 hours in length. Complete in pen.

Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

In case of an emergency notify:

Name: _____ Relationship: _____

Phone: _____ Other Instructions: _____
(Area Code) (Number)

Family Physician: _____ Phone: _____

Insurance Company: _____

Health history:

Have or subject to: (Check all that apply) ___ Asthma ___ Fainting Spells
___ Convulsions ___ Swimming or athletic restrictions ___ Diabetes
___ Heart Trouble ___ Allergies or reaction to any medication, food, or other
___ Other _____ Describe _____

___ Check here if none of the above applies

Have difficulty with: (Check all that apply) ___ Eyes ___ Ears ___ Nose
___ Throat ___ Lungs ___ Digestion
___ Any condition now requiring medication? ___ Name of medication _____
___ Is medication with? If not who has it? _____
___ Any restriction of activity for medical reasons? _____ Explain _____

This health history is correct so far as I know. In the event I am unconscious or in otherwise in capable of making sound judgment on my own, I hereby give permission to the physician, selected by the chapter leadership, to hospitalize, secure proper anesthesia, or to order injection or surgery.

Signature: _____ Date: _____