VOLLEYBALL FESTIVAL 2010
CHAPERONE'S MEDICAL FORM

CHAPERONE MEMBER_____
Last Name First Name Middle Initial
SOCIAL SECURITY # _____

MEDICAL HISTORY

Address_____ Birthdate _____Age_____
City_____State_____Zip_____ Phone (____)_____

In an emergency, please contact:
_____ EmergencyPhone (_____)_____
Print Name/relationship

INSURANCE INFORMATION

Insurance Company _____ Policy # _____
Address _____ Group # _____
City _____ State _____ Zip _____ Phone (_____) _____

MEDICAL HISTORY

I, staff member named above:
l. Have a history of epilepsy: Yes____ No____
2. Have a history of diabetes: Yes____ No____
3. Am subject to one of the specifi ed: sleepwalking_____; ear infections_____; sinus____;
indigestion____; hives____; hay fever____; sore throat_____; bedwetting_____;
appendicitis_____; asthma_____; eye strain_____; heart trouble_____; poison oak_____;
allergic reaction to insect stings, bites_____; list allergies, if any:_____
4. Specific conditions, not covered above, which affect my participation or treatment:
_____
5. Circle diseases you have had: chicken pox, diptheria, German measles, mumps,
scarlet fever, small pox, typhoid, whooping cough.
6. Give year of immunization: Tetanus_____Polio_____
7. Am subject to penicillin or other drug reaction?_____If so, what drug?_____
What reaction?_____
8. I am under special medical or dietary regime. These are listed below:
_____
9.I will bring medicine with me? Yes___ No___ Name of drug:_____
l0. Are there factors which would limit your full participation in activities?_____
If so, please explain:_____
_____
11. Special needs_____