HEALTH FORM
(Adult)

____
Event/Activity/Trip

___________________________________ ______________________
County Dorm and/or Room Number

___________________________________ ________________________
Name Birth Date

____
Street Address City State ZIP code

(______)___________________________________
Home Phone Number

Physical Record of Participant	Yes	No
Heart Condition	___	___
Diabetes	___	___
Polio	___	___
Convulsions	___	___
Ear Infections	___	___
Allergy to any medication	___	___
List medicines allergic to: _______________________________________		
Other allergies (i.e., food, dust, pollen, animals)	___	___
List other allergies ____		

Date of last tetanus shot: ___________________________________
Please list any current medication being taken:
____

Any other medical record information that would be beneficial during the program or in an emergency:

____
In the event of any emergency, I understand that first aid will be administered. I further understand that in case of serious injury or illness, I hereby give permission to the physician selected to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery.

I also understand that, as a result of my participation in this program, it will be necessary for Purdue CES employees and other authorized personnel with the program to have access to my relevant medical information.

Yes ________ No ____________ ____
Signature Date

Note: Check with activity coordinator or local Extension Office to determine whether or not accident insurance coverage is in force for this event.

Persons to contact in case of emergency:

_____________________________________ _____________________________________
Name Home and/or office phone

____
Address

_____________________________________ _____________________________________
Name Home and/or office phone

____
Address