REVISED 6/2003

WASKOWITZ WSU 4-H CHALLENGE ADULT HEALTH FORM

Group Name: _____ Program Date: _____

Name_____Birthdate_____Male_____Female____

Address_____Zip_____

MEDICAL HISTORY

YES	NO			
☐	☐	1.		Do you currently have any physical injuries, complaints, or chronic illness at this time? If yes, **what & for how long**? _____
☐	☐	2.		Have you had injuries in the past (i.e., back, knee, shoulder, elbow, etc.)? If yes, **what & when**? _____
☐	☐	3.		Are you currently under the care of a physician or practitioner of any sort? If yes, **what for & how long**?:_____
☐	☐	4.		Are you taking medicines of any type? If yes, **what & what for?** _____
☐	☐	5.		Are you on a special diet? If yes, what kind:_____
		6.		Do you have or have you ever had:
☐	☐		a.	Diabetes? If yes, are you taking insulin? _____ How much? _____ How often? _____
☐	☐		b.	Seizures?
☐	☐		c.	Asthma? (If yes, **please carry your medication/inhalers with you**.)
☐	☐		d.	Allergies? To what: _____
☐	☐	**	e.	Are you allergic to bee stings? Type of reaction: _____ *If yes, **(please carry your medication with you on the course)**
☐	☐		f.	Any other medical information?_____

7. Emergency Contact Name (please print): _____

Relation: _____ Phone Numbers: _____ _____

Name of Physician:_____

Address: _____Phone:_____

Name of Insurance_____ Group & ID Number_____

I have read the information from the American Heart Association regarding Cardiac Risk on the attached "Risks of Exercise" sheet.

_____ _____

Signature Date