



SOLOMON'S PORCH

2011 MEDICAL HISTORY FORM

Solomon's Porch
PO Box 2267, Wenatchee, WA 98807
17 S. Mission, Wenatchee, WA 98801
509-662-1712

Date: _____

Completed By: _____

Relationship to Youth: _____

Contact Information:

Youth's Name:

First Middle Last

Address:

Number & Street Apt. # City State Zip

Electronic:

Home Phone Cell Email Social Network Site

Personal Information:

BIRTHDATE: ____/____/____ Current Height: _____ Weight: _____ Date of Last Physical Exam: _____

Doctor's Name: _____ Clinic Location: _____ Phone Number: _____

Please list any current health conditions: _____

Please list any medications that the youth will take, and any possible side effects that may occur: _____

Please list the date and reason for any hospitalizations and surgeries: _____

Please explain any significant injuries and include how they were treated: _____

Are there any fears, special needs, or recent events in the youth's life that may impact his/her experience or behavior during the event/trip? If so, please explain in detail, adding another page if needed.

The Solomon's Porch event/trip that the youth will be participating in may include strenuous activities. The youth will be away from our facility with 5-30 other people. The physical and mental environment can be challenging at times. Do you feel that any aspect of the youth's mental or physical health may endanger him/herself, the leaders, or other members of the group? Are there any activities that may physically or mentally cause too much exertion or anxiety on the youth? If so, please explain in detail.

Are there certain situations, conditions, foods, or medications that may trigger a negative (or allergic) reaction in the youth? If so, please list ALL and their effect!

Does the youth have a history of any of the following medical conditions:

- | | | |
|---|-------------------------------------|--|
| <input type="checkbox"/> fainting | <input type="checkbox"/> seizures | <input type="checkbox"/> panic/anxiety attacks |
| <input type="checkbox"/> stomach aches | <input type="checkbox"/> asthma | <input type="checkbox"/> sleeping disorders (sleep-walking, insomnia, or bedwetting) |
| <input type="checkbox"/> Diabetes (I or II) | <input type="checkbox"/> joint pain | <input type="checkbox"/> headaches/migraines |

I certify that the above information is true and accurate to the best of my knowledge:

I AM over 18 years old:

Signature: _____ Date: _____

I AM NOT over 18 years old:

Parent/LEGAL Guardian Name: _____

Signature: _____ Date: _____

Youth Signature: _____ Date: _____

<u>For Office Use Only:</u>
Doctor's Letter (if requested): _____
Program Rep Signature: _____
Notes: _____