Coyote Coast
Youth and Family Counseling, Inc.
A Licensed Clinical Social Work Group

The Coyote Coast Activities Program

HEALTH FORM

(Please print and use backside if additional information is necessary.)

Participant's Name__________________________ Date of Birth______________________ Sex_____________

Address___________________________________City____________State________Zip__________________

Primary Phone # (___) _______________________ Secondary Phone # (___) ____________________________

Participant's Medical Insurance Co.__________________________ Policy #_____________________________

Emergency Contact _________________________Relationship____________ Day Phone (___)_____________

Current Medication:

Name Dosage Schedule Reason for medication

____

____

____

Dietary Restrictions:____

Please check any existing Medical Conditions:

1. Vision or hearing problems? Do you require glasses, hearing aid? _____________________ Yes □ No □
2. Problems with teeth - use of dentures, bridge or braces? ___________________________ Yes □ No □
3. Dizzy spells, fainting, convulsions, persistent headaches? __________________________ Yes □ No □
4. Asthma or respiratory problems? ____ Yes □ No □
5. Palpitation of the heart, irregular heart beat, heart murmurs? ______________________ Yes □ No □
6. Jaundice or hepatitis? ____ Yes □ No □
7. Broken bones, joint dislocations, serious sprains? List_______________________________ Yes □ No □
8. Any severe injury to head, chest, or internal organs? ______________________________ Yes □ No □
9. Allergies to any specific drugs, foods, insects bites, bees? List_______________________ Yes □ No □
10. History of diabetes, thyroid trouble, heart disease? ______________________________ Yes □ No □
11. Other significant medical or neurological disorders? _____________________________ Yes □ No □
12. Do you smoke? ____ Yes □ No □
13. Any specific disabilities? Mental, physical, emotional ______________________________ Yes □ No □

I hereby acknowledge Coyote Coast to administer First Aid and/or emergency medical treatment and/or secure such medical services that may be necessary for myself or any minor on whose behalf I am signing. I realize that any emergency or medications that may become necessary are the sole responsibility of the participant. By signing this release I agree that I have read it carefully, agree with its terms, and I sign it of my own free will.

Signature____ Date_____________________

(Signature of participant or parent/guardian if participant is under 18)

Name (please print) ____

Internal use only
Original □ Copy □