VOLUNTEER MEDICAL HISTORY

NAME: _____

NAME OF PARENT / GUARDIAN: _____

TETNUS SHOT: YES / NO DATE:_____

Height_____ **Weight**_____

AREAS	YES	NO	COMMENTS
AUDITORY:	_____	_____	_____
VISUAL:	_____	_____	_____
SPEECH:	_____	_____	_____
CARDIAC:	_____	_____	_____
CIRCULATORY: (INC. HEMOPHILIA)	_____	_____	_____
PULMONARY:	_____	_____	_____
NEUROLOGICAL:	_____	_____	_____
MUSCULAR:	_____	_____	_____
ORTHOPEDIC: (INCL. SPINAL/JOINT ABNORMALITIES)	_____	_____	_____
ALLERGIES:	_____	_____	_____
LEARNING DISABILITY:	_____	_____	_____
MENTAL IMPAIRMENTS:	_____	_____	_____
PSYCHOLOGICAL IMPAIRMENT: (INCL. BEHAVIORAL)	_____	_____	_____
DIABETES: (NOTE RESTRICTIONS IF ANY)	_____	_____	_____

Medications: _____-_____ _____

Possible side effects: _____

Any health condition we should be aware of:_____

_____

Volunteer/Guardian SIGNATURE: _____

ADDRESS / CITY / STATE:_____

PHONE: _____ **DATE:** _____