Health History and Authorization for Treatment

Seventh Day Baptist Summer Christian Service Corps and Dedicated Service Students attending in-person training.

The following MUST be completed in order for you to attend and participate in SCSC/Dedicated Service this summer.

**HEALTH HISTORY - CONFIDENTIAL -**

Describe your general health?

Limitations, if any:

|  |  |  |  |
| --- | --- | --- | --- |
| Checkif applicable |  | Date | Medications/Treatmentsif applicable |
|  | Diabetes |  |  |
|  | Ear Infections |  |  |
|  | Asthma/Respiratory |  |  |
|  | Convulsions |  |  |
|  | Bleeding/clotting disorder |  |  |
|  | Hypertension |  |  |
|  | Mononucleosis |  |  |
|  | Chicken Pox |  |  |
|  | Mumps |  |  |
|  | German Measles |  |  |
|  | Heart Disease/defect |  |  |
|  | Glasses/Contact lenses |  |  |
|  | Hearing aids |  |  |
|  | Past/Recurring injury |  |  |
|  | **Allergies** to: |  |  |
|  | * Bee stings/other insects / animals
 |  |  |
|  | * Hay fever or plants (poison ivy, etc)
 |  |  |
|  | * Lactose intolerant / gluten/ nuts or other food substances
 |  |  |
|  | * Other
 |  |  |
|  | * Medications (specify)
 |  |  |
|  |  **Fear of, or negative experiences with** any type of animal: cats/birds/dogs, etc. |  | Host families and church families need to know so that they can help you avoid situations. |

Please answer each of the questions below completely and honestly:

1. Have you ever required psychiatric care? Yes No

Explain (include dates)

1. Have you had any major operations or serious injuries? Yes No

Explain (include dates)

3a. Do you have a limiting condition (ADD, LD, Autism, Dyslexia, physical) that the Training Director should be aware of when making assignments of extensive reading and writing? Yes No

3b. What kinds of adaptations would be helpful?

1. Do you have a chronic or recurring illness? Yes No

Explain (include dates)

1. Are there any activities encouraged or limited by physician? Yes No

Explain (include dates)

1. Do you require any dietary modifications? Yes No

Explain (include dates)

1. Are you currently taking any medications? Yes No

Explain (include dates)

Name of your physician: Phone :( )

Date of last physical: / / (Should be within two years of the current date.)

# (\*STOP now and get an appointment set up for your physical if you have not had one recently.)

**INSURANCE INFORMATION**

**Please Note: *In order to participate in SCSC/Dedicated Service—attending training, you MUST have a plan for and be responsible for medical costs.*** *You have the following options*

* 1. **VALID Health Insurance** (applicable in the U.S. or out of the country as in the case of Missions), and supply the SCSC Committee with a copy of your insurance card or information.
	2. **Temporary Insurance.** Further information will follow for those who need to purchase outside insurance.
	3. **Pay for all** medical expenses out of pocket.

# CANADIAN STUDENTS, YOUR INSURANCE WILL NOT WORK IN THE UNITED STATES.

Name of medical insurance company: Name of policy holder: Medical insurance policy number:

Medical insurance customer service or contact phone number

**\*\*REQUIRED\*\* EMERGENCY TREATMENT PERMISSION - CONFIDENTIAL -**

Emergency Contact/Parent /Guardian:

Address: City: State: Zip:

Phone: E-mail:

To the best of my knowledge, the information given in this health history is correct. The person herein described has permission to engage in all prescribed SCSC activities unless otherwise noted.

**Authorization for Treatment:** I hereby give permission for the medical personnel selected by SCSC to order x-rays, routine tests, treatment and necessary transportation for the person herein described. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by SCSC to secure and administer treatment, including hospitalization for the SCSC member named above.

Signature of parent/guardian is **\*REQUIRED** if applicant is less than 21 years of age.

Parent or Guardian Signature Phone ( )

Date: / /