



### ADULT HEALTH HISTORY FORM

Attendee's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Do you have any allergies? YES \_\_\_\_\_ NO \_\_\_\_\_

Please describe: \_\_\_\_\_

Do you carry any medications (epi-pen, inhaler, etc.)? YES \_\_\_\_\_ NO \_\_\_\_\_

List: \_\_\_\_\_

**Emergency contact on day of event (not attending):**

Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

If an emergency should arise which requires immediate medical attention, and I/guardians are unable to give my consent or my emergency contact cannot be reached, you are authorized to initiate whatever steps are needed to protect my health.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



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