Medical History Records Form

I am (*please circle all that apply*) Cincinnati Tradition member, staff or volunteer

PERSONAL INFORMATION

Last name: _____

First name: _____

Middle initial: _____

Sex Date of birth: _____

Primary phone number: _____

Secondary phone number: _____

Permanent street address: _____

City: _____

State: _____

Zip code: _____

PRIMARY EMERGENCY CONTACT INFORMATION

Last name: _____

First name: _____

Relationship to participant: _____

Primary phone number: _____

E-mail address: _____

SECONDARY EMERGENCY CONTACT INFORMATION

Last name: _____

First name: _____

Relationship to participant: _____

Primary phone number: _____

E-mail address: _____

INSURANCE INFORMATION

Please provide a photocopy of the front and back of the insurance card.

Insurance company name: _____

Telephone number: _____

Policy holder's name: _____

Policy number Group number: _____

PERSONAL MEDICAL HISTORY

Check the conditions you have now or have had in the past:

□ Anxiety / Depression
□ Asthma
□ ADD/ADHD
□ Concussion (date of last)
□ Congestive Heart Failure
□ COPD/Emphysema/Bronchitis
□ Diabetes
□ Epilepsy
□ Headaches/migraines
□ Heart disease
□ Irritable bowel syndrome
□ Seizures
□ Stroke/TIA
□ Other _____

Besides medications (which will be listed later), please list any limitations or treatments that you require for the above medical conditions: _____

_____

_____

Please list any non-food and non-medicine allergies (insects, plants, etc.): _____

_____

_____

_____

Please check all that apply with respect to dietary restrictions:
□ I eat everything (no restrictions)
□ Lacto-ovo vegetarian
□ Vegan
□ No red meat
□ Diabetic diet
□ Lactose-free
□ Gluten-free
□ Peanut allergy
□ All nut allergy
□ Shellfish allergy
□ Other _____

Medical History Records

MEDICATION ALLERGIES
Please list any medications you are allergic to (penicillin, sulfa, etc.) and what the reaction is:

Name of medication: _____

Reaction: _____

Please list any medications (both prescription and non-prescription) you are taking:

Name of medication: _____

Reason for taking: _____

Dosage: _____

Frequency: _____

For those under 18: **PARENTS**, please mark the over-the-counter medications that you approve to be given to your child:
□ Ibuprofen (Advil, Motrin)
□ Acetaminophen (Tylenol)
□ Naproxen (Aleve)

□ Diphenhydramine (Benadryl)
□ Throat lozenges
□ Pepto Bismol
□ Loperamide (Immodium)
□ Gas-X
□ Antiobiotic ointment
□ Eye drops (such as artificial tears)
□ Other _____

IMMUNIZATIONS

Please check the immunizations you have received:
□ Hepatitis B
□ DPT (Diptheria, Pertussis, Tetanus)
□ Hib (Haemophilus influenza type B)
□ Pneumonia (Pneumococcal/PCV/PPV)
□ Polio
□ MMR (Measels, Mumps, Rubella)
□ Chicken pox (Varicella)
□ Hepatitis A
□ Meningitis (Meningococcal)
□ Shingles (Zoster)
□ Influenza
□ Tetanus (date of last booster)
□ Other _____

READ BEFORE SIGNING. THIS IS A LIABILITY RELEASE.

I hereby authorize TRADITION to administer over-the-counter medications to me and/or, if applicable, my child. I further authorize TRADITION and its staff, including volunteers to treat any minor conditions which occur. I understand that if TRADITION deems necessary, they will take me and/or my child to a healthcare provider and/or facility for medical care. I authorize all medical care deemed necessary and recommended by medical providers. In consideration for being permitted, or for my child being permitted, to participate in TRADITION activities, I release TRADITION and its staff, including volunteers, from any and all liability for any adverse effects that may occur due to the treatment of minor conditions, administration of any over-the-counter medications and/or any medications prescribed by any licensed medical provider. I further release TRADITION and its staff, including volunteers, from any and all liability in the event that any medications administered, are done so incorrectly or any treatment administered it done so incorrectly. By signing below, I also warrant that all of the above information is complete and accurate and any treatment rendered or misapplication of medications due to inaccurate, incomplete, or unreadable information is not the responsibility of TRADITION or its staff.

Signature of Participant: _____

Date: _____

Signature of Parent/Guardian: _____
(If applicable)

Date: _____