# Medical History Questionnaire

## All Information is Confidential

**We would like to have this questionnaire on file in case of a medical emergency. Filling out this form could provide us with important information if you are injured.**

**Name of Participant:** **Age:**

**Gender: M F** **Date of Birth:**

**Guardian Name:**

**Phone: (Day)** **(Evening)** **(Cell)**

**Home Address:**

**Email Address:**

**In Case of Emergency, Contact:**

**Phone: (Day)** **(Evening)** **(Cell)**

**Physician Name:** **Physician Phone:**

**Yes No** Do you have any allergies? List:

**Yes No** Do you take any medication? List:

**Yes No** Do you have any medical conditions?

**Date of last tetanus immunization:**

**Is there anything else about your health we need to know in case of an emergency?**

**Parent Signature: _____ Date:_____**

Please fill out then mail to CCCB , % Jessica Steines, PO Box 68, Grand Mound, IA 52751 by Friday, Thank you!