



## HEALTH HISTORY

Confidential information completed annually by cadet's parent/guardian.

Cadet Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Social Security # \_\_\_\_\_

Allergies \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Hometown Physician \_\_\_\_\_ Address \_\_\_\_\_

Date of last dental exam? \_\_\_\_\_ Orthodontic Care? \_\_\_\_\_ Date \_\_\_\_\_

Please list any pending care necessary?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has cadet had chicken pox? \_\_\_\_\_ Year? \_\_\_\_\_

If no, has he had the chicken pox vaccine or varicella, Date? \_\_\_\_\_

Mumps? \_\_\_\_\_ Year? \_\_\_\_\_ Measles? \_\_\_\_\_ Year? \_\_\_\_\_ Rubella? \_\_\_\_\_ Year? \_\_\_\_\_

Has cadet had MMR (Mumps, Measles, Rubella) vaccine (x2), Date? \_\_\_\_\_ Date? \_\_\_\_\_

List surgeries	List medications

### Responsible Party

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Relationship \_\_\_\_\_ Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_ SS# \_\_\_\_\_

### Insurance Information

Cardholder Name \_\_\_\_\_

Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer or Group Name \_\_\_\_\_ Company \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Person Code # \_\_\_\_\_ SS # \_\_\_\_\_ Required

Referral Required? \_\_\_\_\_

***(Please include a copy of the front and back of your insurance & prescription card(s))***

***I have checked to make sure my insurance covers emergency care in Kansas.***

Signature of Insured/Responsible Party \_\_\_\_\_ Date \_\_\_\_\_