



Name: _____

Spirit Medical Information and History

Health Insurance
Medical Insurance Company:
Group number:
Policy number or ID:

Doctor's Name	Phone Number	Address

Current medication(s)	Medications you are allergic to

Food you are allergic to	Other allergies

Previous Illnesses	Date	Previous Surgeries	Date

Date of last Tetanus shot:

(If it has been more than 5 years, we suggest that you get a booster shot before tour.)

Did you ever have:	Yes	No	Did you ever have:	Yes	No
Diabetes			Epilepsy		
Asthma			Migraine Headaches		
Bleeding Disorder			Breathing Disorder		
Heart Condition			Back Problems		
Knee or Ankle Problems			Wear Glasses/Contacts		
Carpal Tunnel Syndrome			Arthritis		

If YES, explain:

Medical Release

The information supplied above is correct to the best of my knowledge. The person herein described has permission to engage in all prescribed activities except as noted by me. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by an adult leader of Spirit to hospitalize, secure proper anesthesia, or give any other necessary care to my son or daughter.

Parent or Guardian (If under 18) - electronic signature

Date

Member Signature (If over 18) - electronic signature

Date