

**PERSONAL HEALTH AND MEDICAL HISTORY  
RELEASE**

To be filled out by parent. Please print in blue or black ink.

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_  
Name of parent or guardian \_\_\_\_\_ Telephone \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

**If person above is not available in the event of an emergency, notify:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name of personal physician \_\_\_\_\_  
Telephone \_\_\_\_\_

Health/accident insurance carrier \_\_\_\_\_  
Policy/patient # \_\_\_\_\_

**Check items that apply, past or present, to your health history. Explain any "Yes" answers.**

ALLERGIES: Food, medicines, insects, plants: Yes ( ) No ( ) Explain: \_\_\_\_\_

**GENERAL INFORMATION:**

	Yes	No	Yes	No	Yes	No	Yes	No			
Asthma	( )	( )	Diabetes	( )	( )	High blood pressure	( )	( )	Cancer/leukemia	( )	( )
Heart trouble	( )	( )	Kidney disease	( )	( )	Convulsions/seizures	( )	( )	Hemophilia	( )	( )

**Other** ( ) ( )

Explain: \_\_\_\_\_

List any medications to be taken: \_\_\_\_\_

List equipment needed such as glasses, contacts, etc.: \_\_\_\_\_

**IMMUNIZATIONS: (give date of LAST inoculation or booster)**

Tetanus toxoid \_\_\_\_\_ Measles \_\_\_\_\_ Polio \_\_\_\_\_  
Diphtheria \_\_\_\_\_ Mumps \_\_\_\_\_ Others \_\_\_\_\_  
Pertussis \_\_\_\_\_ Rubella \_\_\_\_\_

**Medical Release**

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the Bonneville Power Administration employee in charge, or who is accompanying my child to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

**Signature of Applicant:** \_\_\_\_\_

**Signature of parent/guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_