HEALTH/EMERGENCY FORM

NOTE: You must complete and return the Health/Emergency form before you can work for Grow Binghamton.

PARTICIPANT INFORMATION

Name: ____

Home Address ____________________________________City: ______________State:_____ZIP:____

Home Phone: ( ) ____________ Cell Phone: ( )____________

☐Female ☐ Male ☐Transgender/Other____________ Social Security Number: ____________

Date of Birth (MM/DD/YYYY): ________ / ________ /_________ Current Age: ______

PARENT(S)/GUARDIAN(S) INFORMATION

Name: ____

Home Address ____________________________________City: ______________State:_____ZIP:____

Home Phone: ( ) ______________ Cell Phone:( )____________ Work Phone:( ) ____________

This person is my: ☐Mother ☐Father ☐Legal Guardian ☐Relative: _____________

PARENT(S)/GUARDIAN(S) INFORMATION

Name: ____

Home Address ____________________________________City: ______________State:_____ZIP:____

Home Phone: ( ) ______________ Cell Phone:( )____________ Work Phone:( ) ____________

This person is my: ☐Mother ☐Father ☐Legal Guardian ☐Relative: _____________

EMERGENCY CONTACT INFORMATION

If the above named individual(s) are not available in the event of an emergency, please contact:

Last Name: ____________________ First Name: ________________ MI: ____

Home Address ____________________________________City: ______________State:_____ZIP:____

Home Phone: ( ) ______________ Cell Phone: ( ) __________________

Work Address ____________________________________City: ______________State:_____ZIP:____

Work Phone: ( ) ____________ Relationship to Participant: ________________________________

HEALTH HISTORY

NOTE: The health history is gathered to assist Grow Binghamton staff in identifying appropriate care. For participants under the age of 18, the health history must be filled out by their parent/guardian. Please provide complete, detailed information (attach additional paper if more space is needed).

Allergies (list all known)
Describe reaction and management of the reaction

☐Penicillin____

☐Insect/bee stings ____________________________________

☐Pollen/hay fever______________________________________

☐Other____

Medications

(routinely taken prescription medication and over the counter drugs) Please include: Dosage and Reason for taking

☐This person takes no medications on a routine basis

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General Questions (explain "yes" answers below)

Has/does the participant:	YES	NO	
1. Ever been hospitalized?	☐	☐	____________________
2. Ever had surgery?	☐	☐	____________________
3. Ever had a head injury?	☐	☐	____________________
4. Ever been knocked unconscious?	☐	☐	____________________
5. Ever passed out during or after exercise?	☐	☐	____________________
6. Ever been dizzy during or after exercise?	☐	☐	____________________
7. Has chest pain during or after exercise?	☐	☐	____________________
8. Ever had seizures?	☐	☐	____________________
9. Ever had high blood pressure?	☐	☐	____________________
10. Been diagnosed with a heart murmur?	☐	☐	____________________
11. Ever had back problems?	☐	☐	____________________
12. Had a recent injury/illness?	☐	☐	____________________
13. Have a chronic/recurrent illness?	☐	☐	____________________
14. Have frequent headaches?	☐	☐	____________________
15. Wear glasses or contact lenses?	☐	☐	____________________

16. Have joint or foot problems? ☐ ☐ ____________________

17. Wear an orthodontic appliance? ☐ ☐ ____________________

18. Have diabetes? ☐ ☐ ____________________

19. Have asthma? ☐ ☐ ____________________

20. Have recurrent gastrointestinal problems? ☐ ☐ ____________________

21. Had psychological counseling? ☐ ☐ ____________________

22. Have any skin problems? ☐ ☐ ____________________

Restrictions to Activity/Additional Information (including physical, emotional, and mental health)

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Participant Agreement: I also understand and agree to abide by any restrictions placed on my participation in VINES Grow Binghamton activities.

____________________	____________________	__________
Name of Participant	Signature of Participant	Date

Parent/Guardian Authorization ***(If under age 18 at start of program)*****:** This health history is correct and complete as far as I know. The participant herein described has permission to engage in all VINES Grow Binghamton activities except as noted.

____________________	____________________	__________
Name of Parent/Guardian	Signature of Parent/Guardian	Date

Additional Comments:

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