

Applicant Health Information

Use A Separate Sheet If Necessary

In case of emergency, please notify: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

List past illnesses:

1. _____
2. _____
3. _____

Please list any allergies, i.e., medicine, foods, etc.

1. _____
2. _____
3. _____

Does applicant take any medications? Yes ___ No ___

If yes, please list all medication(s) and the frequency that medication(s) must be given:

- | | |
|----------|------------------|
| 1. _____ | Frequency: _____ |
| 2. _____ | Frequency: _____ |
| 3. _____ | Frequency: _____ |
| 4. _____ | Frequency: _____ |
| 5. _____ | Frequency: _____ |

Is the applicant current on all required immunizations? Yes ___ No ___

If no, please indicant which immunizations the applicant Is not current:

- DTaP (Diphtheria, Tetanus, Pertussis) _____
- MMR (Measles, Mumps, Rubella) _____
- Polio _____
- Chickenpox _____
- Other: _____

Has the applicant received a COVID-19 vaccine? Yes ___ No ___

Has the applicant had COVID-19 in the last 14 days? Yes ___ No ___

Has the applicant been in contact with anyone who has had COVID-19 in the last 14 days? Yes ___ No ___

Can the applicant swim? Yes ___ No ___

If no, can applicant participate in water activities? Yes ___ No ___

Can applicant participate in sport activities? Yes ___ No ___

If no, please explain.
