

**STAFF/CHAPERONE HEALTH HISTORY 2009-2010**

FULL NAME \_\_\_\_\_

MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ SOC.SEC# \_\_\_\_\_

PRESENT ADDRESS \_\_\_\_\_  
\_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

CHECK ALL THAT APPLY TO YOU: DIRECTOR \_\_\_\_\_  
PARENT \_\_\_\_\_  
BOOSTER CLUB MEMBER \_\_\_\_\_

IF YOU ARE A PARENT, PLEASE LIST CHILD'S/CHILDRENS NAME(S)

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HOME # \_\_\_\_\_ WORK# \_\_\_\_\_ EMERGENCY# \_\_\_\_\_

OCCUPATION \_\_\_\_\_

ANY SPECIAL HEALTH PROBLEMS \_\_\_\_\_

ALLERGIES \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

GROUP# OR IDENTIFICATION # \_\_\_\_\_

**THIS IS PERMISSION FOR TREATMENT OF STAFF/CHAPERONE BY A PHYSICIAN AND /OR AT A HOSPITAL FOR ANY MEDICAL OR SURGICAL EMERGENCY.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

WITNESS \_\_\_\_\_

NOTARY PUBLIC  
SEAL

NOTARY PUBLIC \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_