HealthForm

YADAPP

Youth Alcohol & Drug Abuse Prevention Project

Identifying Information

Last Name

First Name

M.I.

Phone #

Address

City/State

Gender (Male/Female)

Email

Role — Participant | Adult Sponsor | Youth Leader | Junior Staff | Intern

If Participant, what is the name of your Adult Sponsor?

Emergency Contact Information

Name

Relationship

Phone #

HealthForm

YADAPP

Youth Alcohol & Drug Abuse Prevention Project

Parent/Gaurdian Information (if individual is under 18)

Last Name	
First Name	
Relationship	
Gender	(Male/Female)
Address	
City/State	
Phone #	
Email	

Health Information

Indicate known allergies:

☐ YES ☐ NO	Drug/Medications:
☐ YES ☐ NO	Insect bites/stings:
☐ YES ☐ NO	Other:

HealthForm

YADAPP

Youth Alcohol & Drug Abuse Prevention Project

Health Information

Indicate known medical conditions:

☐ YES ☐ NO Asthma:

☐ YES ☐ NO Diabetes:

☐ YES ☐ NO Other:

Have you had Lice or Scabies within the last month? ☐ YES ☐ NO

List all medication that you will be taking while attending YADAPP:

Name of Medicine	Dosage/Amount	Time(s) to be taken

HealthForm

YADAPP

Youth Alcohol & Drug Abuse Prevention Project

Primary Care Information:

Name	
Phone #	

Insurance Information:

Is the person attending YADAPP covered by medical insurance? ☐ YES ☐ NO

Insurance Company:	
Policy Number:	
Cardholder's Name:	

Permission To Provide Care:

In the event of an emergency, _____ may be transported to a local physician and/or hospital and treated as deemed necessary including, but not limited to, medications, anesthesia and surgery. Every attempt to contact the emergency contact and parent/guardian will be made using the phone number(s) provided on this form.

I give permission for the previously mentioned YADAPP attendee to be treated by YADAPP nurses and/or local physicians or emergency room personnel.

Signature: Date:

Parent or Legal Guardian Signature: Date: