



HealthForm

Y A D A P P

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 #



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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:

Once complete, this form should be sent directly to info.nomadnursingLLC@gmail.com