DINÉ Y.O.U.T.H.

MEMBER MEDICAL/HEALTH HISTORY FORM

(Entire form must be completed and signed by the parent/guardian)

Youth's Full Name: _____ Date: _____

Mailing Address: _____ City/State: _____ Zip Code: _____

Date of Birth: _____ Gender: Male ☐ Female ☐

Name of Primary Physician: _____ Hospital: _____

Chart No.: _____ Tribal Census No.: _____

INSURANCE INFORMATION:

Policy Holder: _____ Policy or Group No.: _____

Insurance Provider: _____ Medicaid/AHCCCS ID No.: _____

Has child ever or does he/she have any of the following conditions:

YES	NO	CHECK EACH ITEM	YES	NO	CHECK EACH ITEM
		ADD/ADHD			Hypertension
		Anemia			Knee Injury
		Ankle Injury			Kidney Disease/Trouble
		Arthritis			Loss of consciousness
		Asthma			Neck Injury
		Back Pain			Measles
		Bleeding/Clotting Disorders			Menstrual Cramps (severe - FEMALE ONLY)
		Chicken Pox			Migraine Headaches
		Concussion			Mononucleosis
		Contact with TB Patient			Mumps
		Diabetes			Operation/Fracture Year
		Eczema (skin rash)			Pneumonia
		Elbow Injury			Polio
		Emotional Problems			Rheumatic Fever
		Epilepsy/Convulsions			Scoliosis
		Fainting (Frequently)			Seizures
		Frequent Ear Infections			Sinus Trouble (severe)
		Hearing Trouble			Sore Throat (severe)
		Heart Defect/Disease			Spine Injury
		Hepatitis			Tuberculosis Year
		Hernia			Whooping Cough
		German Measles			Wrist Injury

Do child have any allergies to food, medication, insects, animals, pollen, etc.? ☐ Yes ☐ No

If yes, please list: _____

List presciptions drugs your child is taking: _____

Reason(s) for taking prescription drugs: _____

Is your child receiving medical treatment? ☐ Yes ☐ No If yes, why? _____

Current immunization on file: _____

I give my son/daughter permission to participate in the Diné Y.O.U.T.H. Program. In the event of an emergency or life threating situation and no other alternative is available, I authorize a Diné Y.O.U.T.H. staff member or qualified Emergency Medical Technician to act as Emergency Authorization on my Child's behalf to admit my child to a local health facility for any of the following: emergency examination, treatment, appropriate medications, and/or requried surgical procedures.

_____ _____

Signature of Parent/Guardian (or Participant if over 18 years of age) Date

NOTE : Signature of Parent/Guardian must be on file with Diné Y.O.U.T.H. for youth to participate in program events, activities, and/or field trips.