

CRISIS RECOVERY INTERNATIONAL VOLUNTEERS

Confidential Participant Health Statement

Name: _____
Last First M.I.

Date of Birth: _____
MM/DD/YYYY

Height: _____ Weight: _____ Sex: Male Female

Health History

Have you been seen by a physician or other health provider for any chronic conditions, mental health condition, health problems, or injuries during the past year?

Yes No If "Yes" for what: _____

Please include dates of treatment: _____

Have you been hospitalized or treated in an emergency room during the past year?

Yes No If "Yes" for what: _____

Are you taking any medications: Yes No

If "Yes" for what: _____

List medications: _____

Do you have any allergies to medicine, food, other: Yes No

If "Yes" please list: _____

Describe any restrictions on your activities: _____

Physician's Information

Personal Physician's Name _____

Address: _____

Telephone: _____

Emergency Contact Information

Name: _____

Relationship: _____

Address: _____

Telephone: () _____

Health Insurance Information

Name of Insurance Carrier: _____

Phone Number: () _____

Identifications Number(s): _____

This form will be kept confidential and is maintained by CRI Staff for an emergency.

Signature

Date

Return to Crisis Recovery International Volunteers
PO Box 30766, Lincoln, NE 68503 or Fax to 402.435.1501