

## Teen Health Screening

Name \_\_\_\_\_ Date \_\_\_\_\_  
(First) (Middle) (Last)

Address \_\_\_\_\_ Phone \_\_\_\_\_

**\*\*\* Please circle one response for each of the following questions. \*\*\***

1. Are you under the care of a physician for any reason? YES NO  
If "yes", please explain.
2. Do you take any medications? YES NO  
If "yes", please explain.
3. Do you have any allergies? YES NO  
If "yes", please explain.
4. Is there a limitation on your activity? YES NO  
If "yes", please explain.

***In case of emergency, notify:***

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**A copy of your immunization record must be included with this application. Applicant must show proof of two MMR immunizations.**

Applicant's Signature \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_