

Registrant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PART THREE: Health Insurance and Medical Information**

DeMolay provides secondary health insurance only.

Please list your medical insurance below, *or indicate that you have no medical coverage:*

Insurance Company \_\_\_\_\_ Group No. (if applicable) \_\_\_\_\_ Policy Number \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

**REQUIRED: ATTACH A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARD TO THIS APPLICATION.**

**History:** Please check the appropriate box if you've ever been treated for, or currently have, any of the following conditions:

<input type="checkbox"/>	<b>Asthma</b>	<input type="checkbox"/>	<b>Hepatitis</b>	<input type="checkbox"/>	<b>Lung Disease</b>
<input type="checkbox"/>	<b>Bleeding Disorder</b>	<input type="checkbox"/>	<b>HIV/AIDS</b>	<input type="checkbox"/>	<b>Seizure Disorder</b>
<input type="checkbox"/>	<b>Diabetes</b>	<input type="checkbox"/>	<b>Hospital Admission (w/in 1 mo)</b>	<input type="checkbox"/>	<b>Sickle Cell Disease</b>
<input type="checkbox"/>	<b>Ear/Sinus Problems</b>	<input type="checkbox"/>	<b>Hypertension</b>	<input type="checkbox"/>	<b>Sleep Apnea</b>
<input type="checkbox"/>	<b>Gastric Problems</b>	<input type="checkbox"/>	<b>Implanted Medical Device</b>	<input type="checkbox"/>	<b>Stroke</b>
<input type="checkbox"/>	<b>Head or Brain Injury</b>	<input type="checkbox"/>	<b>Kidney Disease</b>	<input type="checkbox"/>	<b>Surgery within the last year</b>
<input type="checkbox"/>	<b>Heart Disease</b>	<input type="checkbox"/>	<b>Learning Disorders</b>	<input type="checkbox"/>	<b>Other (explain below)</b>

Explain the circumstances of any condition checked above:

**Allergies:** Please list any allergies (medication, food or environmental) and describe your typical allergic reaction if exposed to the allergen:

If you have an allergy, are you prescribed an epi-pen or other emergency medication? \_\_\_\_\_

**Medications:** Please list all medications you are currently taking, including dose and frequency/schedule. Please include inhalers, over-the-counter medications, vitamins and supplements. Please bring only the amount of medicine needed for the duration of the conference in appropriate labeled containers.

Name of Medication	Dosage	Frequency of Dose	Reason for Using

**Immunizations:** **Required** for all Registrants under the age of 24 by New Hampshire law

You must provide either a physician's/NP's/PA's signature below certifying that your immunizations, especially those for measles, are up-to-date, or a copy of your immunization records from your primary health care provider.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_