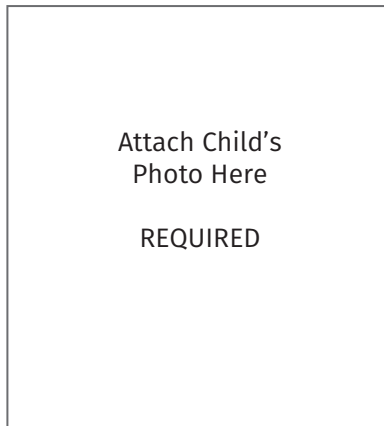


Child Information & Health History



Please Print - Fill out all sections completely

Child's Name _____

Home Address _____ City _____ Zip Code _____

Home Phone _____ Date of Birth _____ Age as of 9/1/20 _____

Guardian 1

Name _____

Address (if different from above)

Home Phone (if different from above)

Work Phone # _____

Cell Phone # _____

Email _____

Guardian 2

Name _____

Address (if different from above)

Home Phone (if different from above)

Work Phone # _____

Cell Phone # _____

Email _____

Emergency contact person if parents are unreachable

Name _____ Phone Number _____

Relationship to child _____

Illness and Injuries (check any chronic or recurring illness and explain below)

- | | | |
|-----------------------------------|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Defect/Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ear Infection(s) | <input type="checkbox"/> Musculoskeletal Disorders |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Bleeding/Clotting | <input type="checkbox"/> Other |

Date of last Health Exam _____ Date of last Tetanus Shot _____

Physician's Name _____ Physician's Phone Number _____

Please explain any other chronic or recurring illness not listed above.

Allergies: (check any that apply and specify nature of allergic reaction below)

- | | | |
|---------------------------------|--|---------------------------------|
| <input type="checkbox"/> Animal | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Pollen |
| <input type="checkbox"/> Food | <input type="checkbox"/> Medications/Drugs | <input type="checkbox"/> Other |

Please list the specific nature of the allergic reaction(s).

Other Health Conditions (check all that apply and describe below)

- | | | |
|--|--|---|
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Emotional Disturbances | <input type="checkbox"/> Fainting | <input type="checkbox"/> Wears Glasses/Contacts |
| <input type="checkbox"/> Special Diet Regimen | <input type="checkbox"/> Visual Impairment | <input type="checkbox"/> Speech Impediment |
| <input type="checkbox"/> Takes Medication (list medication and reason on reverse side) | | |
| <input type="checkbox"/> Other _____ | | |

List any other health conditions you feel the staff should be aware of:

List any medication(s) the participant may take:

Activities your child should be restricted from:

I know of no reason(s) why my child should not participate in activities except as noted above.

Signature of Parent/Guardian: _____ Date _____