HEALTH HISTORY FORM

DATE _____

CHILD'S NAME _____

ADDRESS _____ PHONE (_____) _____

PARENT'S NAME _____ WK NO (_____) _____

EMERGENCY CONTACT _____ (_____) _____
(NAME) (PHONE)

PHYSICIAN _____ (_____) _____
(NAME) (PHONE)

MEDICAL INSURANCE _____
(COMPANY) (POLICY #)

A. ILLNESSES AND INJURIES (CHECK THOSE THAT APPLY)

___ ASTHMA ___ DIABETES ___ EPILEPSY ___KIDNEY DISEASE
___ CONVULSIONS/SEIZURES ___ EAR INFECTION ___ HEART DISEASE

DATE OF LAST HEALTH EXAM _____ ANY PROBLEMS NOTED? _____

IF YES, PLEASE EXPLAIN _____

SINCE CHILD'S LAST EXAM HAS HE/SHE HAD:

A SERIOUS ILLNESS _____ WHAT? _____
AN ILLNESS LASTING LONGER THAN A WEEK _____
AN OPERANTION OR FRACTURE _____
TREATMENT IN A HOSPITAL OR EMERGENCY ROOM _____
RESTRICTIONS FROM PHYSICAL ACTIVITY _____

MEDICATION TO BE TAKEN ON A REGULAR BASIS _____

_____

B. ALLERGIES (CHECK ALL THAT APPLY)

___ ANIMALS ___MEDICINES ___INSECT BITES OR STINGS ___FOOD
___ PLANTS ___HAYFEVER ___POLLEN ___ OTHER

PLEASE SPECIFY _____

C. IMMUNIZATIONS

IMMUNIZATION	YEAR PRIMARY SERIES COMPLETED	YEAR OF LAST BOOSTER
DPT	_____	_____
MEASLES	_____	_____
MUMPS	_____	_____
ORAL POLIO	_____	_____
RUBELLA	_____	_____
TB TIME	_____	_____
CHICKEN POX	_____	_____
HIB HEPATITIS	_____	_____

D. **OTHER HEALTH CONDITIONS** _____

E. **PERMISSION TO SEEK MEDICAL HELP**

IF I CANNOT BE REACHED IN CASE OF EMERGENCY, THE BEARER OF THIS FORM IS AUTHORIZED TO ACT ON MY BEHALF TO SEEK MEDICAL TREATMENT AS THEY DEEM NECESSARY FOR MY CHILD _____

SIGNATURE OF PARENT _____ DATE _____