HEALTH HISTORY INFORMATION AND EMERGENCY CONTACT FORM

(The following information is confidential and will be used only in case of emergency)

Name of child: ______________________________________

Date of Birth: ___/____/_____ Child's Social Security Number: ____-___-_____

Is your child prone to (check those that apply):

___cold ___sore throat ___fainting spells ___bronchitis
___cramps ___convulsions ___allergies (list below)

Does your child have or has ever had (check those that apply):

___asthma ___heart trouble ___lung trouble ___sinus trouble
___hernia ___appendicitis ___appendix removed

Is your child currently under any type of medical treatment? ___yes ___no
Is there any history of behavioral disorders or emotional disturbances? ___yes ___no
Has your child been under the treatment of a psychiatrist in the past three years? ___yes ___no

Date of last tetanus shot: ____/_____/_______

Please list any prescriptions or over-the-counter medications currently being taken:

Name of medication	Dosage	Times to be taken

What medications may we administer? ____

Please list any drug interactions, food or other allergies: ____________ _______________________
____

Does your child have any physical disabilities or disorders that may affect their participation in activities? ____

Are there any special instructions or comments relating to the questions above or to your child's health and their participation in any activities? ____
____
____

Emergency Contact Numbers:

Contact order

___ Father's name: ___________ work phone: ______________ cell phone: _____________
___ Mother name: ____________ work phone: ______________ cell phone: _____________
___ Other: ___________ relation: ____________ phone number(s): ______________________