

Health History

Child's Name _____ Date: _____

Parent or Legal Guardian Name :

Child's age: _____ D.O.B. _____ Weight: _____ Height: _____

Physician's Name _____

Phone () _____ Address _____

Insurance Information: Carrier _____ Group# _____

I. D. # or S.S. # _____

List Three Emergency Contacts for your child:

1. Name: _____ Phone: () _____
Relationship to child: _____

2. Name: _____ Phone: () _____
Relationship to child: _____

3. Name: _____ Phone: () _____
Relationship to child: _____

Below please circle any health problems that pertain to your child now or in the past

And comment below on any item circled:

1. Allergies, including Food Allergies: _____

2. Surgery in last 12 months

3. History of breathing or lung problems

4. Muscle, joint or back disorder

5. Diabetes

6. Overweight/Obesity

7. Family or History of increased cholesterol

8. Family or History of heart problems.

9. Other conditions not listed above: (please describe below): _____

Emergency Medical Treatment Statement

I, the parent and/or legal guardian of _____, give permission to secure emergency medical treatment and/or emergency surgical treatment of my child while in care.

Parent or Legal Guardian Signature: _____

Date: _____

