

HEALTH HISTORY FORM

DATE _____

CHILD'S NAME _____ DATE OF BIRTH _____

ADDRESS _____ PHONE () _____

PARENT'S NAME _____ WK NO () _____

EMERGENCY CONTACT _____ () _____
NAME PHONE #

PHYSICIAN _____ () _____
NAME PHONE #

MEDICAL INSURANCE _____
COMPANY NAME 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 MEDICAL PROBLEMS NOTED _____

IF YES, PLEASE EXPLAIN _____

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

A SERIOUS ILLNESS _____ WHAT? _____

ANY ILLNESS LASTING LONGER THAN A WEEK? _____

AN OPERATION OR FRACTURE? _____

TREATMENT IN A HOPITAL OR EMERGENCY ROOM? _____

RESTRICTIONS FROM PHYSICAL ACTIVITY _____

MEDICATION TO BE TAKEN ON A REGULAR BASIS _____

B. ALLERGIES (CHECK THOSE THAT APPLY)

_____ ANIMALS _____ MEDICINES _____ INSECT STINGS _____ FOOD

_____ PLANTS _____ HAYFEVER _____ POLLEN _____ OTHER

PLEASE SPECIFY IF ANY ARE CHECKED _____

C. IMMUNIZATIONS

IMMUNIZATIONS YEAR PRIMARY SERIES COMPLETED YEAR OF LAST BOOSTER

DPT _____

MEASLES _____

MUMPS _____

ORAL POLIO _____

RUBELLA _____

TB TINE _____

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/GUARDIAN

DATE