

## Health Information

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Child's Name

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Family Physician and **Phone**

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Hospital Preferred

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Food Allergies

Please indicate which of the following conditions your child may have/had and the dates.

\_\_\_\_\_ Seizures

\_\_\_\_\_ Bleeding disorders

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Asthma

\_\_\_\_\_ Heart Condition

\_\_\_\_\_ Other (Please Explain)

Are there any routine medications or treatments your child requires? If so, please list.

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Are there any activities from which your child should be restricted? If so, please list.

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The information I have provided by my written word in regard to my child's information and health history is accurate to the best of my knowledge.

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Name

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Date

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332-8861  
[www.sfasbury.org](http://www.sfasbury.org)